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ABSTRACT

This hearing was called to develop a better understanding of the damage to women and their babies resulting from substance abuse during pregnancy. The hearing transcript addresses prevalence and trends, impacts on mothers and children, impacts on health care costs, impacts on the child welfare system, legal and health policy issues, intervention strategies, and policy recommendations. The document contains statements, letters, and supplemental materials from: (1) Congressional Representatives Thomas Bliley, Jr., Ronald Machtley, George Miller, Nancy Pelosi, Charles Rangel, and Curt Weldon; (2) nurses, doctors, child development specialists, health educators, hospital directors, and substance abuse specialists; (3) attorneys; and (4) a representative of the National Council of Juvenile and Family Court Judges. Included are the findings from a telephone survey of 14 public and 4 private hospitals in 15 cities, and article reprints from a newsletter and two medical journals. (JDD)

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BORN HOOKED: CONFRONTING THE IMPACT OF PERINATAL SUBSTANCE ABUSE

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 27, 1989

Printed for the use of the
Select Committee on Children, Youth, and Families

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BORN HOOKED: CONFRONTING THE IMPACT OF PERINATAL SUBSTANCE ABUSE

THURSDAY, APRIL 27, 1989

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC.

The select committee met, pursuant to call, at 9:50 a.m., in room 2358, Rayburn House Office Building, Hon. George Miller (chairman of the select committee) presiding.

Members present: Representatives Miller, Boggs, Evans, Lehman, Martinez, Rangel, Rowland, Sarpalius, Skaggs, Weiss, Bliley, Hastert, Machtley and Peter Smith of Vermont.

Staff present: Ann Rosewater, staff director; Karabelle Pizzigati, professional staff; Elizabeth Romero, secretary; Dennis G. Smith, minority staff director; Carol M. Statuto, minority deputy staff director; and Joan Godley, committee clerk.

Chairman Miller. The Select Committee on Children, Youth, and Families will come to order.

Three years ago, witnesses warned the Select Committee on Children, Youth, and Families about a very serious problem and that is damage to women and their babies resulting from substance abuse during pregnancy.

Since that time, the epidemic of "crack" cocaine has exploded onto the American landscape. And it has become increasingly clear that pregnant women, infants, and young children are now casualties of this scourge.

The only known national estimate suggests that, in 1988, 11 percent of pregnant women used drugs during pregnancy, and that some 375,000 newborns annually may be damaged by drug exposure. But, aside from this estimate and a few specialized studies, little is known about the extent of substance abuse or the nature of its impact on pregnant women and infants.

To understand this emerging phenomenon better, I asked my staff at the select committee to talk with hospitals in large metropolitan areas about their experiences. Today, I am releasing the results of this survey.

Our findings are profoundly disturbing. Not only do they confirm the escalation of drug exposure among newborns but they underscore the urgency of action on all fronts.

A detailed accounting of our findings accompanies my statement, but I would like to review a few major points.

Fifteen of the 18 hospitals surveyed reported 3 to 4 times as many drug-exposed births since 1985. In some hospitals, one in six of all newborns are born "hooked."

Drug exposed babies are more likely to be born prematurely and have low birth weight, dramatically raising their risk of infant mortality and childhood disability.

Women who seek help during pregnancy cannot get it. Two thirds of the hospitals reported that they had no place to refer substance-abusing pregnant women for treatment.

Hospitals in Los Angeles and Washington, D.C. reported the reemergence of maternal death during labor and delivery, directly attributable to drug abuse during pregnancy.

Eight hospitals reported a growing number of "boarder" babies who remain in hospitals because their parents abandoned them or cannot afford to care for them.

The broad brush picture painted in this survey illustrates the devastating impact of substance abuse on America's most vulnerable citizens. While the number of drug-exposed babies remains relatively small compared with all babies born in America, they are among the most expensive babies we now care for. And, these children have the ability to swamp every system involved with their care, from hospitals to child protective services to foster care to schools.

Hospitals we surveyed cautioned that their estimates vastly undercount the number of women and children affected. They indicated, as well, that these newborns stay in hospitals up to 13 days longer than healthy infants, at a cost that can reach nearly $1800 a day.

These problems no longer are confined to the inner cities. In my suburban district in California, 40 babies a month are born drug exposed and these children now represent 60 to 70 percent of the foster care case load in the county I represent.

Congress has recently targeted additional resources to prevent and treat drug abuse during pregnancy. But as our evidence on the front lines demonstrates, these efforts remain too slow and too few.

Today we will hear from nurses, doctors, educators and others who daily see the implications of this crisis for families and communities across the country. What these witnesses graphically describe symbolize in my view the tragic effect of a decade of national neglect. It is my hope that our witnesses will enlighten us on a problem that demands not only greater exploration but much more dedication to remedies that work.

OPENING STATEMENT OF CONGRESSMAN GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Three years ago, witnesses warned the Select Committee on Children, Youth, and Families about a very serious problem: damage to women and their babies resulting from substance abuse during pregnancy.

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The only known national estimate suggests that, in 1988, 11 percent of pregnant women used drugs during pregnancy, and some 375,000 newborns annually may be damaged by drug exposure. But, aside from this estimate and a few specialized studies, little is known about the extent of substance abuse or the nature of its impact on pregnant women and infants.

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ADDICTED INFANTS AND THEIR MOTHERS

A SURVEY PREPARED AT THE REQUEST OF
CONGRESSMAN GEORGE MILLER, CHAIRMAN
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

INTRODUCTION

Three years ago, the Select Committee on Children, Youth, and Families conducted a hearing on infants at risk due to parental addiction and disease. Since that time, it is apparent that there has been an explosion in the availability and use of illicit drugs, especially crack cocaine. To understand the scope of addictions among pregnant women and the effects on their children, I asked the staff of the Select Committee on Children, Youth, and Families to sample the experiences of major municipal hospitals around the country.

In response to my request, the staff conducted a telephone survey of 14 public and 4 private hospitals in 15 cities, including 9 of the most populous cities. (Cities in which hospitals were surveyed include: Boston, Chicago, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, New York City, Oakland, Philadelphia, Phoenix, San Antonio, Seattle and the District of Columbia.) Interviews with obstetricians and gynecologists, neonatologists, social workers and administrators in one or two hospitals in each of these cities provided the basis for our observations. While the study is by no means definitive, nor is the sample scientific, the findings which emerge offer a snapshot of the prevalence and impact of drug addiction on pregnant women and their newborn infants.

The survey questions centered on trends in births of drug-exposed infants, whether and how infants and/or pregnant women are screened for illegal substances, length of hospital stay, and costs associated with substance-exposed infants. Staff requested data on the following illegal substances individually or in combination: cocaine, heroin, PCP, marijuana, or any other measured. Although the survey focused principally on illegal drug abuse, experts agree that alcohol and/or tobacco use often accompany other drug use and pose serious risks of poor birth outcomes. Data provided on alcohol and/or tobacco use were also recorded.

While the newness of the problems, their rapid increase, and lack of uniform data prevent our obtaining a precise count of drug-exposed births, the experiences of hospital staff are undeniably and remarkably comparable -- and their observations and concerns are similar on several points.

PRINCIPAL FINDINGS

TRENDS IN BIRTHS OF DRUG-EXPOSED INFANTS

1. **Of the 18 hospitals surveyed, 15 (14 public and 1 private) reported an increase in the incidence of substance abuse during pregnancy and the number of drug-exposed births since 1985. (See Notes 1a, b, c.)**

Eight hospitals surveyed had trend data available:

- A hospital in **Dallas**: based on maternal histories, the number of drug-exposed newborns increased from 65 of approximately 3410 total births to 192 of 3360 total births between 10-12/1987 and 10-12/1988.

- A hospital in **Denver**: based on maternal histories, the number of drug-exposed newborns increased from 32 of 2875 total births to 115 of 2924 total births between 1985 and 1988.

- A hospital in **New York City**: based on newborn toxic screening, the number of drug-exposed newborns increased from 12%-13% of 2900-3000 total births in 1985 to 15% of 2900-3000 total births in 1988.

- A hospital in **Oakland**: based on newborn toxic screening, the number of drug-exposed newborns increased from 6% to 18% of the approximate 2400 total births per year between 1985 and 1988.

- A hospital in **Philadelphia**: based on newborn toxic screening and maternal histories, the number of drug-exposed newborns increased from 4% of approximately 1078 total births in the period 7/1/87-12/31/87 to 15% of 1105 total births in the period 7/1/88-12/31/88.

- A hospital in **Washington, DC**: based on newborn screening and maternal histories, the number of drug-exposed newborns increased from 5.7% of 1994 total births in 1985 to 18% of 1812 total births in 1988.

- A hospital in **Detroit**: based on maternal histories, the number of narcotics-exposed infants (which primarily reflects maternal cocaine use and, to a much lesser degree, heroin use) increased from 9.1% of 1111 total clinic births in 1985 to 10.4% of 1781 total clinic births in 1987.

- A hospital in **Houston**: based on maternal histories, the rate of drug-exposed infants admitted to the neonatal intensive care unit has increased from 1.73/100 to 4.9/100 between 7/1/86-6/30/87 and 7/1/87-6/30/88.

2. **Of the 18 hospitals surveyed, 9 suggested that the numbers of drug-exposed infants and substance-abusing pregnant women were undercounted.** According to these hospitals, the undercount can be attributed to maternal denial of drug use, lack of clinician sensitivity to indicators of drug use, and the inaccuracy of toxic screening which has high false negatives and only detects substance use within the previous 24 hours.

   - In a Miami prevalence study, only 27% of the pregnant women testing positive for drug use at labor and delivery had admitted drug use. (See Note 2)

   - A pediatrician in a Detroit hospital reported that urine toxicologies only detect 37% of the positive drug-exposures because of the test's high rate of false negative.

3. **Hospital neonatologists and pediatricians cited similar physical and behavioral conditions of drug-exposed newborns: prematurity, low birthweight, hypertonicity, and low Apgar scores are frequent characteristics among newborns born to mothers who used drugs during pregnancy.** (Survey data received may reflect single or polydrug assessment.)

   - Hospitals in Detroit and Miami reported that approximately 1/3 of drug-abusing pregnant women had premature newborns. (See Note 2.)

   - A Washington, DC, hospital reported that 18% of its drug-exposed newborns had low birthweight, as compared to 12% of the non-exposed newborns.

TRENDS AMONG SUBSTANCE ABUSING PREGNANT WOMEN

4. **Hospitals commonly found that substance-abusing pregnant women frequently suffered abruptio placenta and unexplained hypertension. Two hospitals reported maternal death during labor and delivery.**

   - A Los Angeles hospital reported that 3 maternal deaths in 1988 were attributed to drug ingestion.

   - A hospital in Washington, D.C. reported the re-emergence of maternal death associated with labor and delivery as a result of "crack" cocaine use.

5. **Four of the 18 hospitals surveyed stated concern about the increase in cases of venereal disease and increased risk of HIV infection among their patients, many of whom are substance-abusing women.**

   - A prevalence study of newborn drug-exposure at a New York hospital found a 495% increase in the number of reported syphilis cases among women between 1985 and 1988.

   - Several hospitals mentioned concerns regarding the risk to drug-exposed newborns of becoming HIV-infected because of the prevalence of the virus among intravenous drug users.

6. **Most of the hospitals surveyed reported that since 1980 "crack" cocaine has become the drug of choice.**

   - A hospital in Oakland reported that 90% of newborns with positive toxic screens showed cocaine exposure.

   - In a Houston hospital, the percentage of pregnant substance abusers reporting cocaine use increased from 2% in 1980 to more than 80% in 1989.

   - A Chicago two-week prevalence study found that, at labor and delivery, 55% of the women reporting drug abuse used cocaine.

7. **Respondents from several hospitals mentioned that alcohol**

consumption is a significant part of the polydrug pattern of substance abuse among pregnant women.

- Based on maternal histories, a hospital in Detroit found that 11.5% of births over several months in 1988 were to women who reported alcohol consumption during pregnancy.

HEALTH CARE FOR ADDICTED PREGNANT WOMEN

8. **Seven of the 18 hospitals surveyed reported that substance-abusing pregnant women were up to 4 times less likely to receive prenatal care than other women.**

   - According to a responding obstetrician at a Miami hospital, 30% of substance-abusing women do not obtain prenatal care compared with 15% of other women.

   - A Dallas hospital reported that 50%-70% of substance abusing pregnant women do not receive prenatal care compared with 15% of other women.

9. **Twelve of the 18 hospitals surveyed reported that they have no place to send pregnant women for drug treatment.**

   - For pregnant women addicted to cocaine in Boston, there are approximately 30 residential treatment slots in the city. At a hospital in Boston, according to maternal histories, 18% of the 1700 mothers delivering there use cocaine.

   - A hospital in Los Angeles noted a 10 to 16 week waiting period for drug treatment, even for pregnant women.

PLACEMENT OF DRUG-EXPOSED INFANTS

10. **Eight of the 18 hospitals surveyed reported that drug-exposed newborns medically cleared for discharge regularly remain in the hospital for various reasons including the lack of available and appropriate foster care placement or delayed protective services evaluation.**

    - On a given day, a Miami hospital houses 20-30 "boarder" babies who may remain in the hospital for up to a month. The hospital attributed the high number, in part, to the effect of new state law which places all drug-exposed newborns under state custody, overwhelming the foster care system.

HOSPITAL COSTS

11. **Although no cost studies specific to drug-exposed babies have been conducted, 8 of the 18 hospitals surveyed referred to the high cost of care for low birthweight and sick babies, an increasing number of whom have been exposed to drugs. Often born prematurely or suffering withdrawal symptoms, drug-exposed newborns typically have longer stays in the hospital, frequently in the intensive care nursery (ICN).**

    o A Los Angeles hospital estimated the average cost of a drug-exposed newborn in the ICN is approximately $750/day for a mildly drug-exposed newborn and $1768/day for a severely affected infant.

    o Eight of the 18 hospitals estimated that cocaine-exposed newborns also tended to stay 1 to 13 days longer than healthy newborns, though not in special care.

12. **Six of the 18 hospitals mentioned a lack of resources to confront the problem of drug-exposed newborns.** They cite the costs associated with drug screening, prevalence studies and "boarder" babies.

NOTES

1.a. None of the 18 hospitals surveyed reported routinely screening all newborns or pregnant women for drug exposure. 15 of the 18 hospitals surveyed screen newborns if there are reasons to suspect drug-exposure, based on maternal history or report, or clinical signs. 8 of the 18 hospitals surveyed screen pregnant women if there are reasons to suspect drug abuse.

b. There is no uniformity in drug screening or data collection. That is, the way in which hospitals assess drug use and the resulting data bases vary hospital to hospital. This is to some extent due to the lack of adequate research protocols or agreement among medical and other experts as to the nature, appropriateness and consequences of such screening and/or reporting.

For example, 4 of the 9 hospitals which reported undercounting the numbers of drug-exposed newborns and/or substance-abusing pregnant women, showed a marked increase in the number of drug-exposed newborns simultaneous to hospital efforts to maintain data.

c. Three of the 4 private hospitals surveyed (Miami, San Francisco, Seattle) did not have data on drug-exposed newborns or substance-abusing mothers. None of these three reported an incidence of drug-exposed newborns over 2%. The hospitals said that the substance-abusing women primarily attended the area public hospital, except in emergency cases. The obstetricians and neonatologists explained that they did not routinely inquire about drug use when taking maternal history.

2. Bandstra, E.S., Steele, B.W., Burkett, G.T., Palow, D.C., Levandoski, N., and Rodriguez, V. "Prevalence of Perinatal Cocaine Exposure in an Urban Multi-ethnic Population." Pediatr Res, April, 1989 (In press).

I'd like at this time to recognize the ranking Republican member of this committee, Mr. Bliley of Virginia.

Mr. **Bliley**. Thank you, Mr. Chairman.

The subject of today's hearing on the impact of maternal drug use on unborn and newborn children illustrates precisely why the Select Committee on Children, Youth, and Families exists. This issue cuts across the jurisdictional lines of several standing congressional committees; but through its universal approach, the select committee has the opportunity to help shape the future debate and national policy on how to respond to the tragedy of maternal drug use and its effects on babies. Illegal drug use is a tragedy not only for the woman who is so hooked on the drugs that she engages in behavior that severely and irreversibly harms her unborn child, but it is a tragedy for the child that is handicapped by being born at greater risk of diminished capacity, at greater risk of severe birth defects, at greater risk of infection, including AIDS.

Those who contend that illegal drug use is a victimless crime must step forward and view the destruction on the streets in so many cities across this nation, the damaged lives that are brought into emergency rooms and delivery rooms in too many of our hospitals. Experts say we are producing a new generation of "innocent addicts." Estimates run as high as 375,000 newborns a year who are born hooked due to maternal drug use. This epidemic causes newborns, only hours old, to suffer painful withdrawal from the drugs their mothers ingested, tremors, prenatal strokes, irritability, deficits in language, mental and motor development and a litany of other threats to life. Maternal drug use during pregnancy is a situation that demands intervention, but what type of intervention, by whom, and when, are the questions to be addressed in today's hearing.

Let me say at the outset that I believe we as a society have an obligation to protect the life of the unborn child whose mother is a drug addict. There is no constitutionally protected right for a pregnant woman to abuse drugs. This is indisputable.

Mr. Chairman, I ask your unanimous consent to revise and extend my remarks for the record.

Chairman **Miller**. Without objection, it will be done.

[Opening statement of Hon. Thomas J. Bliley, Jr., follows:]

Opening Statement of Hon. Thomas J. Bliley, Jr., a Representative in Congress From the State of Virginia, and Ranking Republican Member

The subject of today's hearing on the impact of maternal drug use on unborn and newborn children illustrates precisely why the Select Committee on Children, Youth, and Families exists. This issue cuts across the jurisdictional lines of several standing Congressional Committees; but through its universal approach, the Select Committee has the opportunity to help shape the future debate and national policy on how to respond to the tragedy of maternal drug use and its effects on babies. Illegal drug use is a tragedy not only for the woman who is so hooked on drugs that she engages in behavior that severely and irreversibly harms her unborn child, but it is a tragedy for the child that is handicapped by being born at greater risk of diminished capacity, at greater risk of severe birth defects, at greater risk of infection, including AIDS.

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Several issues challenge us at today's hearing. First, what resources are provided or needed. Let's look at what we are spending at the federal, state, and local level in drug programs.

Several anti-drug initiatives are already underway that ought to be addressing this problem: The Anti-Drug Abuse Act of 1988 contains $34 million for drug abuse demonstration projects to treat pregnant women and their children, with an additional $9.5 million for special programs for this population. In fiscal year 1989, the Office of Maternal and Child Health and Office of Substance Abuse Prevention will fund about 25 grants specifically targeted at substance abusing pregnant and post partum women and infants at a cost of $4.5 million. The National Center for Child Abuse and Neglect has funded projects designed to reduce the risk of neglect and abuse in infants born to addicted mothers with the total funding at over one million dollars. The fiscal year 1990 funding estimate for the Alcohol, Drug Abuse and Mental Health Services Block Grant is $800 million with an increased set aside for programs affecting women—that is, a 10-percent set aside for programs such as the ones we will be discussing today.

While the Federal effort is significant, the states and counties contribute even more: almost 60 percent of the total money for treatment and prevention services. Expenditures for alcohol and drug abuse treatment and prevention services were over $1.8 billion in fiscal year 1987. Of the total expenditures, States provided $924 million or 51 percent, while Federal sources provided $324 million or 18 percent, county or local sources contributed $165 million or 9 percent and other sources contributed $396 million or 22 percent.

In addition to programs that provide specific anti-drug activities there are a number of programs designed to provide general assistance to pregnant women and infants. I believe that many of the women and children that we will talk about today are already eligible for Medicaid, WIC, Maternal and Child Health Block Grant funds, the Preventive Health and Health Services Block Grant, not to mention food stamps and AFDC. If these children are born impaired they are eligible for funds under the Developmental Disabilities programs, as well as the Education for the Handicapped Act. If these children are abandoned then we have the Foster Care Program and Child Welfare Services. My point here is that part of the solution lies in the way services are delivered. Are these women participating in programs that we already have? If not, why not? Do we need to do more outreach? Do we need to coordinate services better to provide more comprehensive services at one site? I want to see why the target population we are speaking of is not receiving the necessary care. Should existing programs be serving them already; and if so, why aren't they?

The services which exist for other persons in need, whether educational, or medical, or other social services must also be available to the child disabled by these powerful drugs. This is every public manager's problem and the challenge is twofold: to prevent further destruction and to put those lives which have already been destroyed back together.

To assure that individuals receive necessary care requires different services through a complex delivery system. But the message to the public as a whole is quite simple and just this: Drug use makes a mockery of the principles of a free people. While a person always carries within him or her the freedom to choose particular courses of action, that person taking drugs ought to be held accountable for his or her actions. If we are led to believe that a person is not responsible for his or her actions in taking drugs, what does this mean for self-government?

We are in grave danger of confusing the power of government with what makes our nation strong. The strength of our nation is not found under the Capitol dome or at 1600 Pennsylvania Avenue nor at the judges' bench—it is our homes, schools, churches, and communities. If we as parents do not protect our sons and daughters from drugs, we cannot expect government to. We cannot expect our children to correctly choose between right and wrong if we do not teach the clear distinctions between them at home and in the classroom.

In examining this issue, we are forced to expose the veneer of life and liberty in America today. Our judicial system has determined that women may make reproductive choices concerning the outcomes of their pregnancies. How does this affect the choices made by drug addicted women who endanger the health and lives of the unborn babies by this high risk behavior?

It is true enough that "the purpose of law is to lead those subject to it to their own virtue." But, do not search for the remedy to heal the wounds of drug abuse, it is nowhere other than within each of us. Victories will become elusive and public spirit will crumble if success is measured only by the size of drug busts and convictions. Victory will not come amidst blaring trumpets and smashing headlines, it is in the quiet humility and dignity of a million charitable and faithful homes.

I believe that we need to thoughtfully and exhaustively review all of the problems of drug addicted mothers and their babies before us today. I look forward to all of the testimony and hope that it will bring this problem into sharper focus.

Chairman MILLER. Mr. Machtley.

Mr. MACHTLEY. Thank you, Mr. Chairman. I would like to take this opportunity to applaud the efforts of this Select Committee on Children, Youth, and Families on confronting an issue that may not be glamorous, or popular but it's of vital importance to our nation and its continuing preservation and its economic future.

The issue of course is indeed a tragic one, that of children who are born hooked to addictive substances. We rise today to give voice to those that as of yet have no voice of their own, the unborn children.

An estimated 375,000 newborns each year are threatened with the effect of exposure to drugs while in the womb. These children are born already at a disadvantage. They face serious health and learning problems, among other complications.

Furthermore, there is a greater chance the children who are exposed to these harmful substances during development will be born premature. It could cost as little as $290 per child to bring a child to full term yet some $440,000 is needed for remedial medical and academic care when a child is born prematurely. Thus, adequate prenatal care is undoubtedly a sound investment in medical dollars alone.

I think it is important for us to identify those programs that have shown to be effective and focus our energies on existing programs that work. In addition, more can be done to better coordinate federal, state and local efforts to ensure that as many people are benefiting from these programs as possible.

We owe it to the future generations to do a better job than we are doing today. We must also take a moment to explore the underlying causes behind this growing trend of drug abuse among all segments of society, including pregnant women.

If a major cause includes loss of hope and self esteem then we must turn to our educational system to infuse in our young people the notion that drugs do not in and of themselves solve problems. They merely create them.

We must confront this problem head on, for the health and well being of these innocent children is at stake. Our country has a future and children are part of that future. I look forward to today's testimony as a means of establishing an opening and continuing dialogue that will lead us to a solution of this very grave problem.

Chairman MILLER. Thank you.

OPENING STATEMENT OF HON. RONALD MACHTLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

I would like to take this opportunity to applaud the efforts of this Select Committee on Children, Youth, and Families on confronting an issue that may not be "glamorous" or "popular", but is of vital importance to our nation and its continuing preservation. The issue, of course, is indeed a tragic one—that of children who are born "hooked" to addictive substances.

We rise today to give voice to those that as of yet have no voice of their own, the unborn children. An estimated 375,000 newborns each year are threatened with the effects of exposure to drugs while in the womb. These children are born already at a disadvantage. They face serious health and learning problems, among other complications.

Furthermore, there is a greater chance that children who are exposed to these harmful substances during development will be born premature. It costs roughly as low as $290 dollars to bring a child to full term; yet, some $440,000 dollars is needed for remedial medical and academic care when a child is born prematurely. Thus, adequate pre-natal care is undoubtedly a sound investment in medical dollars.

I think that it is important for us to identify those programs that are shown to be effective, and focus our energies on existing programs that work. In addition, more can be done to better coordinate federal, state, and local efforts to ensure that as many people are benefitting from these programs as possible. We owe it to these future generations to do a better job.

We must also take a moment to explore the underlying causes behind this growing trend of drug abuse among all segments of society, including pregnant women. If a major cause includes loss of hope and self esteem, then we must turn to our educational system to infuse in our young people the notion that drugs do not solve problems; they merely create them.

We must confront this problem head on, for the health and well-being of these "innocent addicts" are at stake. I look forward to today's testimony as a means of establishing an open dialogue that will lead us to a solution of this very grave problem.

Mr. Lehman.

Mr. **LEHMAN**. I just wanted to say that although the headlines that you read in the papers in Washington and other metropolitan areas are about the murders and deaths from drug wars, to me there is a much more subtle form of murder and death and life long disabilities that results from the mothers that do have the cocaine addiction problem and pass it on to their innocent children. These children are just as much victims of the cocaine and drug problem as any victim that was shot down in cold blood in the streets of D.C.

Chairman **MILLER**. Thank you. Congressman Rowland who is not only a member of this committee, but also the vice chair of the National Commission to Prevent Infant Mortality. Dr. Rowland?

Mr. **ROWLAND**. Thank you for focusing attention on this problem and I look forward to hearing the witnesses.

Chairman **MILLER**. Let's get on with the hearing. Thank you. Our first panel will be made up of Margaret Gallen who is Director of Nurse Midwifery at the Department of Obstetrics and Gynecology at D.C. General Hospital; Dr. Neal Halfon who is director of the Center for the Vulnerable Child at Oakland's Children's Hospital, Oakland, California. Jeffrey Parness is a professor of law at Northern Illinois University. Wendy Chavkin who is a Rockefeller Fellow at Columbia University School of Public Health and Haynes Rice who is the Hospital Director from Howard University Hospital in Washington, DC.

If you'll come forward and join us at the table, we'll take your testimony in the order in which I called your name and we welcome you to the committee and appreciate you taking your time to give us the benefit of your knowledge and expertise.

Let me at the outset thank you for all the help you've already given the committee in putting this hearing together. I'll tell you how much we appreciate it and Margaret we'll start with you.

STATEMENT OF MARGARET GALLEN, G.N.M, M.S.N., DIRECTOR OF NURSE MIDWIFERY, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, DISTRICT OF COLUMBIA GENERAL HOSPITAL, WASHINGTON, DC

Ms. GALLEN. Good morning. My name is Margaret Gallen. I'm director of The Nurse Midwifery Service at D.C. General. I've been a registered nurse since 1953 and a nurse midwife since 1969. I have been at D.C. General since 1974 so I've been there for a long time and I've seen many changes.

I am happy today that I've been invited to come and let you know what changes have occurred, most especially in the last two years because of this whole crack epidemic we have.

D.C. General for all of you who are from the city already know is literally a stone's throw away, well within a jogger's trip from this building itself. We share a very large 26 acre campus with the Substance Abuse Program this city runs, T.B. clinics and venereal disease clinics. We're a very, busy place.

The problem that we're having now just to illustrate, in 1987, January, February and March one mother in ten on admission in labor admitted to usage of drugs. This past January, February and March of 1989 it's one woman in five so that we're minimally 20 percent and so far in the month of April we're now running 21 percent. That let's you know how things are changing while you watch them.

Of course this is self admission. This does not say what the actual figures are. We do not do toxicology screens on every woman who comes into the hospital, only those who show some signs or symptoms of having a problem.

But the numbers alone don't really tell you what's happening. Let me describe a few of these incidents.

Recently we've had a 25 year old woman who was admitted unconscious in labor with a history of seizures at home. Her urine toxicology screen was positive. She woke up three days later after having delivered, to say, "when can I eat." It might sound humorous but the cost of the care of a woman like this to the hospital is astronomical. We've had to do CAT scans. She's had total nursing supervision 24 hours a day for those three days let alone what's going on within her own body and the baby that was delivered. What happened to that baby?

We had a 13 year old girl brought in pregnant who had been incarcerated and was in a juvenile home in the city and the reason why she had been arrested was because she had the job of transporting crack back to Washington from New York City. Any group of people that is going to use a 13 year old pregnant kid to do the job is terrible.

We had a woman come in having delivered the baby and placenta at home, not really sure when she had delivered. The baby was dead. She had been using crack for a couple of days.

One of our worse tragedies was a 38 year old woman who came in semi-comatose having had seizures at home, still clutching the crack in her hand and the hand had to be opened and the crack given to our security guard. The woman was dead in a matter of hours. They were able to do a Caesarean section, get a live baby, but the woman died in the delivery room itself.

This is a maternal mortality and for those who are not familiar with the figures in maternal mortality we have been doing very well with that in this country but you're going to see a real change in the next couple of years.

We have had a woman come in in the last six weeks with a revolver in labor and the reason why she was carrying a revolver was she said, someone was after her, so they took the revolver and she had a policewoman attend her.

We have evidence all around us of the kind of aggression that's caused by crack. We always now have a security guard on the department, when there's visiting hours. We've had to bring in security just because we can't get people to wait until real visiting hours start. Our adolescent mothers create an even worse problem. If they're going to be successful mothers they have to have support from the rest of the family and the rest of the family now is deteriorating. We have girls who can't bring the baby home because the home has turned into a crack house. Things have really changed very dramatically.

I go to the jail to give classes, prenatal classes, child birth classes and we're seeing a change over there. The women are very free in describing what crack is doing. It's different than the old problem of heroin and for the women who used to be on heroin they are now also on crack as well. P.C.P. users use crack, marijuana users are also now using crack. So there's been a big difference.

The problem with crack is if you are not familiar with it, it's a lot cheaper than cocaine—the old cocaine you heard about with movie stars. Crack is cocaine but it's been changed in a way that it's a lot cheaper and easier to transport.

The big difference is that it has an immediate effect. It hits the brain, dilates, not dilates but constricts blood vessels and has an immediate high as far as the mother is concerned and really causes a big problem for the baby at that time.

The mother will excrete cocaine crack into her urine but the baby does the same thing and the baby then will excrete the crack into the amniotic fluid. For the mother the high is finished in 20 minutes. But, the baby keeps drinking the amniotic fluid containing the crack so the baby's high lasts for days. So there's a big difference. Babies are being born, because of the constant high that they live with, having had strokes. In some cases the constriction of blood vessels has cut off circulation to limbs and babies have been born without fingers, toes, that kind of thing.

The irritation of the crack cocaine on the vessels and on the uterus can cause premature labor. It can cause abruptio placentae so we're seeing an increase in abruptio placentae which means the afterbirth comes off the wall of the uterus. This has been shown all over the country, now today when you see that situation you do want to do a toxicology screen on the mother because you see it so much more often today than you used to.

It's really causing us a terrible problem. The problem for the mother is much greater than the problem is for nonpregnant women. The other problem is that people are paying for their crack with sex which means we're seeing more pregnant women using drugs than we had seen before and those same women are having increased incidents in sexually transmitted diseases, the sexually transmitted diseases that are resistant to some of the miracle drugs that we used to have. So we're going to see a big increase in sexually transmitted diseases too.

What does all this mean? I think for us it means that it's really a pandemic. It's not an epidemic any more It's covering everybody and everything.

I've included in my testimony an article from Northern Virginia that occurred in Pediatrics Magazine in this last month on the incidence among middle class and upper middle class white teenagers and young people.

Mortality and morbidity figures for both mothers and babies are going to rise much higher than what they were.

Our AIDS situation is going to change because these women are exposed and not using safe sex at all.

Our gynecological cancer rates are going to go up because other kinds of viruses are being passed around. We just don't have the time for discussion anymore that we had with some other problems. There is an estimate that 90 percent of all people who start on crack do become addicted. It's different altogether with some of the other drugs and the person can hit bottom in about 6 months, I've seen that happen. I've seen women who have had good jobs in this city, computer operators at NASA, people working in Crystal City for example, with federal contractors, they've lost their jobs, their family won't tolerate them anymore, literally living in the street and at shelters. So you might not start out poor, but you'll end up poor in a very short period of time if you use this drug.

The effect on the school system in the near future I can't even begin to think about it. We're going to end up with thousands of babies who have been blighted and we need help. There's no doubt about it.

What kind of help do we need? We need to be able to get the story out exactly as you're doing today, to get people to understand that crack cocaine is not the same drug; not that any of them are any good, but it's different. We need more social workers, we need more counselors. We need in-patient facilities so that we can keep women who are coming to us asking for help and so that we can help them out. Right now we really don't have much to offer them because we can't separate them from where they're living. We need public health nurses and if I might say so we could use many more nurse midwives because it's been shown that we do work well with these kinds of women.

I don't know what else we can do, though, until we are able to keep the cocaine from coming into the country because it's too pervasive at this stage.

Thank you.

Chairman **Miller**. Thank you very much.

[Prepared statement of Margaret L. Gallen follows:]

PREPARED STATEMENT OF MARGARET L. GALLEN, CNM, MSN, DISTRICT OF COLUMBIA GENERAL HOSPITAL, WASHINGTON, DC

Good morning! My name is Margaret L. Gallen, CNM, MSN, I have been a Registered Nurse since 1953 and a Certified Nurse Midwife since 1969. My entire professional experience has been in the area of Maternal and Child Health both in the United States and in Africia. I have been the Director of the Nurse Midwifery Service at D. C. General Hospital since 1975 but have been associated with the Nurse Midwifery Service there since January 1974. I welcome your invitation to speak here today because it is important that you are informed of the change that has taken place in the past few years on the Obstetrical Service at D. C. General as a result of the ever increasing use of "Crack/Cocaine" by our expectant mothers, fathers and close family members.

D. C. General Hospital is located at 19th & Mass. Ave., S.E., literally a "stones' throw" from the Capitol Building. It shares a twenty-six acre campus with the D.C. Jail, and D. C. Department of Human Services out-patient and in-patient substance abuse facilities, a mental health clinic, sexually transmitted disease clinic and tuberculosis clinic. Our metro stop has been named "Stadium-Armory" though I can't imagine why as those facilities function only occasionally and our campus almost explodes with activity daily.

I realize that throughout the entire nation, there is a growing concern about chemical substance abuse and its attendant ills including increased violence, crime, child abuse and maternal and newborn sickness and death.

Let me tell you how this plays out in Washington, D. C. in 1989.

First, a review of even very "raw" statistics show that in the months of January, February and March of 1987 one laboring mother of every ten coming into our Admissions Office in labor responded positively to the physician's question "Are you using any drugs." For January, February and March 1989 one mother in five answered "yes". To date this month has shown a one percent increase over the previous three months. How many other mothers decline to answer truthfully we do not know as a Toxicology Screen is not a part of routine laboratory tests gathered but is performed with the patient's knowledge only if signs or symptoms of substance abuse exist. Statistics gathered by our Neonatologists show a slightly higher number in babies exhibit symptoms or narcotic withdrawal than those mother originally admitted to usage. We conduct a separate prenatal clinic for mothers who are known substance abusers so that their pregnancy might be monitored and managed with special attention paid to the earliest signs of certain kinds of pathology to which these mothers are most at risk of developing. Currently there are nearly ninety mothers registered in this prenatal clinic.

Numbers alone cannot give you the full picture of what is now becoming an almost daily occurrence; that of a woman pregnant, "high" on drugs with extreme anxiety for her own and her baby's life stating that she has lost control of her own ability to resist the compulsion to smoke "crack". She comes literally begging the hospital to admit her to the Obstetrical Unit to protect her from herself. Consider the following scenarios which have all occurred since January and show so well some other evidence of usage.

a. A twenty-two year old prenatal sustance abuser in the midst of a discussion of treatment for a sexually transmitted disease, tears up her medical record and leaves without treatment thus continuing to expose her baby and sexual partners.

b. A twenty-five year old woman is admitted unconscious, in labor with a history of siezures while at home. Her urine toxicology positive for cocaine and she wakes up three days after delivery asking to eat, I know that this possibly sounds hunorous but along with the effects of the drug upon her own and her baby's body the care of such a patient costs an enormous amount of non-refundable money for diagnostic procedures, laboratory studies, and intensive nursing care.

c. A thirteen year old pregnant and incarcerated in the City's Receiving Home is brought to the Obstetrics and Gynecology Department at D.C. General. Allegedly, she is in custody for transporting "crack" from New York to Washington.

d. A twenty-eight year old mother comes into the hospital by ambulance with a four pound eight ounce dead male newborn and placenta, claiming she last free based cocaine three days prior to delivery.

e. A thirty-eight year old pregnant woman comes to the hospital by ambulance having seizures, semi-comatose but still clinging to a piece of "crack". A live infant is delivered by emergency Cesarean Section but the mother dies, while still in the delivery room. An anonymous telephone call informs us that the dead woman was using "crack" continuously for the preceding twenty-four hours. A local University Hospital has lost two other mothers in the past six months in almost identical circumstances.

f. A mother comes into the hospital in labor carrying a revolver for her own protection and saying someone is out to get her. The gun is confiscated by the Metropolitan Police and she spends her hospitalization accompanied by a policewoman. This demonstrates the extent of the violence in Washington, D.C.

g. Casual vistors to the Obstetrical Unit frequently come before the "Vistors' Hour" starts. Previously it was usually quite easy to ask the person to take a seat in the waiting room and watch the television while waiting. Now a security guard must occasionally be called because of the suddent burst of anger that comes when a reasonable request to be seated is made. Security guard is now always assigned to the postpartum unit during visitors hours. Another instance of our need to respond to the intense aggressiveness that "crack" brings forth.

h. Our adolescent mothers present a new problem because frequently now their families are unable to be as supportive as they might have been and must be, if the young unexperienced mother is to be successful as a parent. I have cared for one adolescent, pregnant with her second child, whose two aunts were as she said "free-basing in the basement" while she needed their support! It was Christmas time, the young mother wanted to do something special for her toddler, she went to Goodwill and purchased a table and chairs and placed them under the tree. The aunts stole the set sold them on Christman Eve and bought more cocaine.

We have had young mothers who cannot take their babies home to their own mothers because the home has been turned into a "crack house". The stories are endless and each one presents a new and different problem especially for the social worker who will tell you that the options for referral in these situations have just about disappeared; the system is completely overloaded.

i. The DC Jail has numerous young mothers and expectant mothers within its population. The pregnant women receive their prenatal care and deliver at D.C. General. Responding to their need for information concerning maternal and child health, I with the help of other professionals set up a series of fifteen classes which meet weekly. We lead discussions, answer questions, show films, etc. The overwhelming majority of the women have been at least users if not sellers of illicit chemicals and most recently "crack" seems to be the most popular. The women are quite open in discussing the intensity of the addiction and the rapidity with which a person loses control over their life. Recently a woman described how her neighbor sold her baby to someone just to get enough money to satisfy her compulsion.

j. Recently we have heard of instances where women, knowing that it causes irritation of the uterus have purposely taken crack to induce labor or to affect a speedy labor. A mother at the jail described how she delivered a nine and a half pound baby in an hour while under the influence of "crack". Her question to me was "Why was

I bleeding so hard and why were the doctors in such a hurry?" Taking crack to induce labor might sound like a good idea but:

1. A precipitous labor can cause brain damage in the newborn.
2. The instance of miscarriage and premature labor and delivery are already increased for this group and we surely do not need more. At the District of Columbia General Hospital the prematurity rate for the group is eighteen percent vs. twelve percent for the rest of our patient population.
3. The irritation of the uterus can be of such a level as to cause abruptio placenta meaning that the afterbirth is peeled off the wall of the womb before delivery of the baby causing at the very least hemorrhage which would rapidly deteriorate into death of baby and mother.

I realize that this all sounds melodramatic but it only illustrates how the chemical changes induced by "crack/cocaine" on the brain have pervaded and poisoned the total community. Why is my continuous referral to "crack/cocaine" rather than to heroin or PCP? Because "crack" is now the "drug of choice" in the District and even those who have been using heroin for years are now also smoking crack as it provides the ultimate "high". Authorities report that PCP used alone is fast becoming a rarity, most now use PCP and crack together to achieve a more gradual "low". Crack itself is often smoked with marijuana.

What makes this drug and its route of administration so damaging? I've enclosed some additional information with my written report but basically you should remember that crack is a highly concentrated form of cocaine: that it costs far less than the traditional "avant-garde" form of cocaine hydrochloride thus making it within the reach of even the most modest pocketbook; that is causes in laboratory animals observable and reproducible changes in brain chemistry which makes addiction almost a certainty; that by smoking crack/cocaine rather than snorting it, the desired effect is almost instantaneously achieved but it wears off very quickly thus, necessitating the use of more drug very quickly.

What makes crack usage such a problem in pregnancy? First, you need to know that when a woman is pregnant her metabolism increases considerably because she really is breathing for two, eating for two, voiding for two etc. even to the point that the mother's thyroid gland is enlarged. Now you add "crack" which in a matter of seconds makes all her blood vessels constricts, makes her blood pressure literally shot up, her heart beat so fast she will tell you that it feels as though it's about to jump out of her chest, you can imagine what this does to an already overloaded system. Too, in normal circumstances there is more than a pint of blood going to the maternal uterus each minute where it is to deliver oxygen to the baby and take away his carbon dioxide. With such constriction of the mother's blood vessels, the blood supply is decreased, the baby does not get an adequate supply of oxygen, and slowly but surely the carbon dioxide builds up in his body because it can't be taken away fast enough. The real emergency comes when the pressure in the mothers' blood vessels becomes so high that it is able to force the afterbirth off the wall of the uterus.

Something else you should be aware of is the fact that the cocaine goes out of a person's body through the kidneys. A pregnant woman's kidneys are already working overtime so the cocaine stays in her system longer that it would if she were not pregnant. To make matters worse, the baby too excretes his cocaine through his kidneys but into the amniotic fluid. He now takes his own supply of cocaine by mouth independent of his mothers' and his supply will last for days, until it is all filtered out of his amniotic fluid. Because constriction of the baby's blood vessels goes on for so nuch longer than does those of his mothers' body, babies are born with symptoms of having had brain strokes while in the mother's uterus.

Why do we have so many more women pregnant when using crack than we had in years past with heroin using women? Simple, the women are using sex to pay for their crack and in their desperation there is little thought given to safer or responsible sex. As a result we are now seeing more addicted pregnant women but we are also seeing an increase in sexually transmitted diseases throughout the community. Incidently more and more frequently we are also noting that the germs causing these "STD's" are resistant to the "miracle drugs" we once though were going to solve all of our venereal disease problems.

What assessment can we make after my depressing review of the Crack / Cocaine problem?

a. This is not an epidemic it is a pandemic. If you doubt this read the enclosed article which appreared in this month's issue of "Pediatrics." It graphically discribes the level of crack usage by the adolescent, young adult white, middle and upper middle class population of Northern Virginia.

b. Maternal and Infant (morbidity and mortality) sickness and death statistics for the United States will surely rise in the near future.

c. AIDS in the heterosexual non-IV drug abusing population will surely rise in the near future.

d. Gynecological cancer rates will surely rise in the near future as certain other types of viruses are passed around.

e. We do not have too much more time left for discussion when you realize that it has been estimated that ninety percent of crack users become addicted and that from first "high" till the person "hits bottom" can take as little as six months.

f. The effect on the school system across this Nation in the next few years can only be imagined as they are challenged by an increase in the numbers of socially and physically impaired children.

g. Metropolitan areas which have been hit the hardest need HELP, HELP, HELP.

What kinds of help do we need?

a. We need to tell the true story of how distructive "crack" is but we need to do it quickly. We don't have the luxury of time that we have had with tobacco, good nutrition, exercise, and cholesterol education. This might mean that we must be graphic, a little crude in the eyes of some but we must get point across and NOW.

b. We desperately need more inpatient and outpatient detoxification and rehabilitation facilities. Maybe some women actually do need to be therapeutically housed prior to delivery in this current emergency.

c. We need more counselors and social workers so that they have adequate time to give intensive therapy to more women especially in the first few months after delivery when under the stress of new motherhood the woman is more apt to return to drug.

d. We need to have the financial ability to closely monitor the growth and development of the babies for at least three years so that therapeutic intervention can occur soom as possible after the problems are identified.

e. We certainly need to return to the concept that the Community based nurse is worth her weight in gold. Public Health nursing in this country is almost non-existant at the present time. This tragic loss of professional expertise has reached such a level that it will take time to re-establish the speciality as there are not presently sufficient numbers prepared. Nursing traineeships to encourage graduate education in this area of expertise is a primary need.

f. A re-examination of the delivery of health care to mothers is needed. Certified Nurse Midwives have shown a unique ability to work well with addicted mothers in urban areas. These mothers are "comfortable" interacting with the certified nurse midwife and respond well to her efforts to educate and instruct the mother in a more positive approach to pregnancy, childbirth and motherhood. As a result the mother is more apt to keep appointments and follow the midwife 's advice. Utilizing a "group approach" to health care, the midwife is certainly professionally prepared to manage the care of most of these mothers. A Challenge is to prevent future drug usage to prevent further damage; the midwife's approach is based upon prevention. Again the numbers of prepared nurse midewives is presently inadequate to the need and financial assistance to interested young nurses is basic.

Finally, I feel that we all must truely wish to solve this problem in a definitive way if we are to succeed in saving this generation. It seems though that this will be impossible until we are able to succeed in preventing cocaine from entering our country.

Again, Thank you for giving me an opportunity to speak to you today.

Respectfully Submitted by

Margaret Gallen

Margaret L. Gallen, CNM,MSN

In consultation with

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AND

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Staffs on the Maternity Units of
D.C. General Hospital

substance facts
from The Psychiatric Institute of Washington, D.C
September 1986

Crack: Cocaine In New Clothes

1985 and 1986 may become known as the years that both current cocaine abusers and neophytes alike discovered *crack*. Since *crack* first began appearing as a major drug of abuse, its use has become epidemic in New York City and is now found throughout the nation.

A May 1986 New York Field Division Report of the Drug Enforcement Administration (DEA) calls *crack* the street drug of the future. The report noted that *crack* has found popularity at rates which surpass even the discovery and initial abuse of such substances as PCP and LSD. Other cities, including Washington, D.C., are bracing for the crack "explosion" which officials expect. In July 1986, D.C. Metropolitan Police seized a substantial quantity of *crack* packaged for sale when they stopped a motorist for speeding.

The Dealer's Dream

Crack has been called a "Dealer's Dream." It is enormously profitable and is simple and safe to process from street cocaine—cocaine hydrochloride. An ounce of pure cocaine hydrochloride can produce as many as 280 vials of *crack*. *Crack*, which looks like slivers of soap and feels like porcelain, is sold in 100 mg. ready-to-smoke doses for as little as $5.00 to $10.00 per dose which makes it very appealing to a "fast food" generation user. *Crack* is also potently addictive so that in spite of its low per dose cost, it becomes one of the most expensive drug habits.

Crack's addictive potential is such that DEA officials in New York City concluded that once a person starts using it, he/she cannot stop. According to the DEA report, "people depleted their life savings to buy *crack* and people, upon leaving a *crack* house with no money, commited crimes in the immediate area to get more money for *crack*."

Smoking Cocaine: The Most Compulsive Form Of Cocaine Use

Smoking cocaine is a very different drug experience than snorting, or using cocaine intranasally. When smoked, the onset of intoxication is more rapid, almost instantaneous though the effects last only half as long as when snorted. After the "high" from each dose dissipates, users experience an often crushing depression, feel irritable or agitated and have a "drug hunger" that demands more cocaine .

Not only is smoking cocaine a different experience, it is by far the most compulsive cocaine behavior, accelerating the progression from first use to addiction. By contrast, the usual pattern of addiction for snorting may take several years. When cocaine is smoked, the progression may take just several months.

Smoking cocaine also may predispose the user to "binging" in which smokers may use from 10-50 grams of cocaine over a 1 to 2 day period. Users who switch from snorting to smoking may quickly double or triple their weekly dosages.

Additionally, there are indications that "binging" has increased among intranasal users with people using a week's supply in the course of a weekend or in several hours. One wealthy man in the metropolitan area reported having spent $250,000 on cocaine

continued on page 2

GHOSTBUSTERS,
SPACE BLASTER, BAZOOKA, or **SUPERCRACK**—all refer to a new drug combination, crack mixed with PCP. This combination of stimulant with hallucinogenic drug sells on the street for between $10.00 and $15.00 per dose. PCP, sold in combination with marijuana, costs about the same. Both drugs alone have accounted for increases in violent crime wherever their use has been high.

Though not a major problem in this area at present, "Ghostbusters" may become a special problem in the future for the Washington, D.C. area as PCP use already is well-established in the drug-abusing community.

Smoking Cocaine— —from page 1

in 2 years. Spending up to $1,000 for an evening, he felt, was worth the expense.

Smoking cocaine is apparently considered a "safer" alternative to intravenous cocaine use because of possible exposure to the AIDS-related virus through contaminated needles.

Smokeable Cocaine Products

Cocaine currently is being smoked in three forms:

• ***CRACK*** appears to be the predominant substance now smoked with its low per dose cost, purity and accessibility playing a major role. All these factors make it a very marketable product from the pusher's standpoint.

• **BASUCO** is a coca paste derivative which is an intermediary product in the processing of coca leaves to street cocaine. It is contaminated with lead and petroleum distillate residues. Basuco is the least expensive form of cocaine at around $1.00 to $2.00 per dose. Currently, basuco smoking is primarily seen among individuals directly involved in the processing chain.

• **FREE-BASE.** Free-basing, which requires expensive and bulky paraphernalia as well as expertise to use volatile chemicals such as ether to separate the cocaine base from cocaine hydrochloride, has declined in popularity. *Crack* and basuco—as less expensive and less explosive alternatives—have supplanted free-basing as the coke smoker's choice.

About Cocaine

Cocaine is a water-soluble stimulant drug extracted from the leaves of the coca plant grown in South and Central America. When smoked, snorted, injected, ingested or applied to mucous membranes, cocaine has an immediate effect on the body, dilating the pupils and increasing blood pressure, heart rate, breathing rate and body temperature. Cocaine acts directly and almost immediately upon the brain and central nervous system. It is this brain stimulation that makes cocaine so alluring and so dangerous.

Cocaine changes the brain's chemistry by interfering with the normal chemical activity in the brain. It blocks uptake of certain neurotransmitters, in particular dopamine, and acts upon the so-called pleasure centers of the brain.

The immediate and short-lived effects of cocaine reportedly make users feel euphoric, confident and more energetic until the depression after use occurs.

Part of the lure is that many people feel they can concentrate better and perform better in a variety of tasks, with many users reporting enhanced sexual pleasure. However, with extended abuse, depression can become chronic, and hallucinations and signs of psychosis may appear. Some users have difficulty concentrating or remembering things, lose interest in sex, may become impotent, or have panic attacks.

Deaths directly attributable to the effects of cocaine use may involve seizures, cardiac arrest, or respiratory failure. Deaths from suicide or accidents or from the hazards of a cocaine lifestyle are also real threats, especially to the heavy user.

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Published as a public service, *Substance Facts* is a new newsletter providing information about drugs and about drug-related issues.
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Cocaine Use Nationally

The National Institute on Drug Abuse in their 1984 report on drug use in the United States estimated that there were 22 million persons who had tried cocaine, with 4 to 5 million regular users. Another 5,000 persons each day were estimated to have tried the drug for the first time. These figures predate the upsurge of *crack* use.

Cocaine Dependence

Cocaine dependence or addiction may be defined as the compulsion to use the drug and the absolute loss of control over and continued use of the drug in spite of obvious physical, social and psychological consequences. Serious disruptions within the family, on the job or in social situations occur for the out-of-control user. When cocaine becomes an obsession, users' thoughts are disorganized, their judgement fails and their existence becomes dismal.

Sources:

Street Pharmacologist, Vol. 9, No. 1, January 1986, UpFront, Inc., Miami, FL

"*Crack*" Special Report—A New Form of Cocaine Abuse,". May 28, 1986, Drug Enforcement Administration, New York Field Division, Unified Intelligence Division

Dr. Arnold M. Washton, Research Director, "800-COCAINE" National Hotline, May 8, 1986, Testimony before the N.Y. State Senate Committee on Investigations and Finance

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Ronald K. Siegel, "New Patterns of Cocaine Use: Changing Doses and Routes," *ibid.*, 1985

Donald R. Wesson and David E. Smith, "Cocaine: Treatment Perspectives," *ibid.*, 1985

How Cocaine Affects The Body

- **Central Nervous System.** Stimulation of the system produces euphoria, talkativeness, irritability, suspicion, and convulsions, seizures and death.
- **Arteries.** Blood pressure increases 10 percent to 15 percent. The blood courses through the vessels at a more rapid speed and may cause, in some cases, brain hemorrhage.
- **Eyes.** Pupils may dilate, becoming more sensitive to light. It may cause the abuser to think he sees "halos" surrounding objects on which he attempts to focus. The halo effect is often called "snowlights" by users.
- **Heart.** Heartbeat becomes more rapid, increasing by 30 to 50 percent, and may become irregular in rare instances. It could cause heart attack and stroke.
- **Lungs.** Chronic crack smoking may lead to hoarseness and bronchitis, similar to the effects of marijuana or tobacco smoking and to chest congestion with black sputum.
- **Sexual Functioning.** Chronic cocaine use can result in a loss of interest in sex and decreased sexual performance.
- **Nose.** Chronic cocaine "snorting" can result in a deterioration of the nasal septum.

How Cocaine Affects The Mind

- **Depression.** Users experience crushing depression when the euphoric character of intoxication abates. Chronic depression may be one result of prolonged use.
- **Suicide or Suicide Attempts.** Frequently persons dependent on cocaine see suicide as the only viable solution to deteriorating health, personal, domestic, financial and work situations.
- **Psychosis, Paranoia, Delusions, Hallucinations.** Users may hallucinate and feel little insects ("cocaine bugs") crawling under the skin.

OVERVIEW OF DRUG TREATMENT PROGRAMS AT THE PSYCHIATRIC INSTITUTE OF WASHINGTON, D.C.

The Psychiatric Institute of Washington offers a full spectrum of drug abuse treatment programs for adolescents and adults. These programs treat people who abuse drugs by helping them alter the patterns of behavior associated with drug abuse. Drug abuse treatment services include:

ADULT DRUG ABSTINENCE PROGRAM	The Adult Drug Abstinence Program is an inpatient treatment program designed for drug-dependent adults (age 18 or older) who require an intensive, structured environment for diagnosis and treatment. Patients typically spend 28 days in the program during which time detoxification takes place under close medical supervision. Prior to discharge, an outpatient aftercare program will be recommended to the patient based on his or her individual needs.
PIDARC	The Psychiatric Institute Drug Abuse Rehabilitation Center (PIDARC), a non-profit program of The Psychiatric Institute Foundation, operates an outpatient clinic for adults age 18 or older. PIDARC treats users of narcotics, poly-drugs or cocaine who do not require hospitalization. The program is Medicaid-qualified by the District of Columbia.
GATEWAY	Gateway is an intensive, eight-week inpatient treatment program for adolescents (age 13 to 18) who suffer from the combination of chemical dependency and emotional/developmental problems. Families are closely involved in all phases of treatment. The program includes one year of free aftercare for eligible candidates.

GETTING HELP...

Cocaine abuse eventually presents a crisis of major proportions for individuals and families. The Clinical Assessment and Referral Service (CARS) of The Psychiatric Institute of Washington is one resource available to provide information and to help families and individuals find appropriate treatment for substance abuse. Highly experienced therapists can provide crisis intervention, evaluations, referrals to psychiatrists and other mental health professionals or agencies, as well as counseling and information. Individuals may call to schedule a confidential consultation at one of our CARS locations. Immediate or next-day appointments are available and are free of charge.

In addition to helping individuals and families assess possible problems with drug or alcohol abuse, CARS therapists see people who may be unable to cope with many other personal problems–such as, trouble with children, broken relationships or divorce, deaths or illnesses of loved ones, trouble at work or the loss of employment. The CARS therapist can evaluate each situation and make recommendations aimed at helping the individual or family understand their situation and reduce their symptoms of anxiety and distress.

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Heavy Cocaine Use by Adolescents

Deborah E. Smith, BM, BCh, Richard H. Schwartz, MD, and David M. Martin

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ABSTRACT. Adolescents are susceptible to becoming cocaine users. Twenty-eight teenagers in a drug rehabilitation program were identified as heavy cocaine users and questioned about their experiences. They reported family conflict leading to running away (86%), school drop-out (24%) and delinquent behaviors such as stealing (96%) and vandalism (57%). Cocaine use started at 14 years for 21%, with progression from onset to at least weekly use within eight weeks (54%). Side effects included sleep disturbance (18%) and tolerance to cocaine (25%). Withdrawal was characterized by cocaine craving up to one month later (93%). The majority (96%) were polydrug abusers. Possible causes of teen substance abuse are discussed, and the importance of prevention is emphasized. *Pediatrics* 1989;83:539–542; *cocaine, adolescent.*

Cocaine use has increased dramatically since the last decade, particularly in older adolescents and young adults. This increased use of cocaine reflects lower costs and increased availability[1]; indeed, cocaine is now seen as readily available by almost half of high school seniors.[2] The annual surveys of the National Institute on Drug Abuse indicate that in 1986 17% of high school seniors tried cocaine at least once, compared with 9% in 1975.[2] The actual prevalence of cocaine use is probably higher because school drop-outs are not included in the National Institute of Drug Abuse data.

Although previously believed to have no serious side effects, medical complications of cocaine abuse are now well recognized,[3] and cocaine is known to be highly addictive. In laboratory animals, it is more toxic than heroin[4] and preferred to food even when the alternative is starvation and death.[5] Cocaine dependence was not listed in the *Diagnostic and Statistical Manual of Mental Disorders*, ed 3, because symptoms of tolerance and cocaine withdrawal were not then appreciated. However, phases of cocaine withdrawal have now been described, including cocaine craving potentially lasting several months.[6] From the National Institute of Drug Abuse data, 0.8% of high school seniors report cocaine dependence.[2] Adolescents are particularly vulnerable to chemical dependency for both developmental and psychosocial reasons.[7] Although the pediatric literature includes descriptions of cocaine, its abuse, and management of intoxication,[8] there is limited information concerning adolescent cocaine use.[9,10] The following is a report of results of a survey conducted to explore the habits and experiences of a group of teenagers who became dependent on cocaine and participated in a rehabilitation program.

METHOD

Patient Population

Straight Incorporated is a not-for-profit, private, drug rehabilitation program for adolescents and young adults. The majority of "Straight" clients are white and from middle- to upper-class suburban families. Ages range from 13 to 24 years, and alcohol and marijuana are the most common drugs of abuse. Approximately 10% are ordered into treatment by the judicial system; the remainder are referred by their families. The program is conducted in various locations, and each operates independently. For this study, adolescents were selected from four different sites.

Study Procedure

To identify frequent cocaine users, all adolescents enrolled at one site within a 15-month period were given a self-administered questionnaire after

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Reprint requests to (D.E.S.) Department of Pediatrics, Children's Medical Center of UVA, Charlottesville, VA 22908.

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they had been in the program for 1 month. By this time it was hoped that they could respond more honestly than when admitted to the program.

Additional heavy cocaine users were selected from three other Straight sites by general questioning about cocaine experience during group therapy sessions. Those teenagers who reported having used cocaine on more than 50 occasions were then asked to complete the same questionnaire used at the first site. All participants were anonymous on their questionnaires, and the information obtained from the surveys was not shared with personnel at the client's rehabilitation site; confidentiality was thus maintained. At all sites, participation was entirely voluntary. Clients were not induced to participate and suffered no consequences if they refused.

RESULTS

Twenty-eight teenagers were identified as having used cocaine on more than 50 occasions. Of these teenagers, 15 came from the first Straight site selected from the 200 rehabilitation clients who answered the questionnaire. The additional 13 heavy cocaine users came from three other sites, recruited as described. In all, there were 21 boys and seven girls, aged 15 to 17 years. This group represented 6% to 7% of clients in this age range in the Straight programs surveyed. In answering the questionnaire, 19 (68%) described themselves as being completely truthful in their answers, and the remaining 9 (32%) reported being truthful at least 80% of the time.

About half (54%) came from intact families, and 87% lived with at least one parent. Almost all (96%) had fathers who had completed high school, and 82% described their family income as average or above. Five of the 28 cocaine users had siblings who were chemically dependent. Seventy-five percent had parties with alcohol and drugs in their homes without parental knowledge. Almost half (46%) of the respondents believed that their parents had no suspicions about their drug or alcohol use even when this was occurring more than twice a week during a 12-month period or longer. When their parents were aware of the drug involvement, 54% of the teenagers still did not receive help for more than a year. Before starting illicit drug use, these teenagers described themselves as being lonely (31%) or depressed (14%) and having problems at school with attention difficulties (52%) or poor grades (28%). By the time of admission to the drug rehabilitation program, 24% had left high school without graduating. Skipping classes many times a day was reported by 43%, and 93% had received some disciplinary action at school including suspension or expulsion (71%). Eleven (39%) of the teenagers had attempted suicide, five (18%) on two or more occasions. Although they had received therapy while involved with drugs, 32% believed that their therapist never appreciated the drug dependency, even after three or more visits. Five teenagers had attended therapy sessions while intoxicated.

Vandalism while intoxicated was reported by 57% of the respondents, and 50% had been detained or arrested by police. Driving while intoxicated was reported by 36%, with 25% being involved in accidents.

Five of the 28 respondents had initiated drug use by 10 years of age and 27 (96%) reported having used drugs at least six times by 14 years of age. By the time of admission for rehabilitation, in addition to cocaine, other drug use included marijuana (93%), 16 (57%) reporting use of more than 28 g (1 oz) of marijuana in the 30 days before admission. Alcohol use was also common (93%) with 21% describing daily drinking and 86% being inebriated more than five times in the previous year. Amphetamine abuse was reported by 86%.

Cocaine Use

By 14 years of age, 21% of the teenagers identified as heavy cocaine users had already tried cocaine, and more than half of them (64%) reported progressing to at least weekly use within 1 to 2 months of initiation. Before entering the drug rehabilitation program, 46% of the group had been using cocaine on a daily basis, 21% for the previous 4 months or more. Almost all (89%) of the teenagers had friends of their own age who used cocaine, and all described their social lives as revolving around their drug use.

Seventy-five percent of the teenagers studied used at least 3 g of cocaine per month and the majority (68%) by "snorting." Approximately half of these snorted more than four "lines" on each occasion of use. Only one person admitted to intravenous cocaine use, and three preferred inhalation of free base cocaine. Eighty-two percent of the respondents reported morning drug use. Most (79%) felt unable to refuse cocaine and were afraid to stop using it.

One quarter of the heavy cocaine users described spending at least $250/wk on cocaine during a 3-month period, and two individuals claimed to have spent $1,000/wk on cocaine. Money was obtained from a variety of sources, including a steady job (18%), dealing drugs (21%), and prostitution (11%). Almost all (96%) admitted to stealing, 43% claiming to have stolen more than $1,000 worth of goods.

Physiologic side effects described were limited to the sense of agitation associated with acute cocaine use. To minimize this, respondents had on occasion mixed cocaine with other drugs, including marijuana (68%) and alcohol (25%). None of the teenagers reported having seizures. Psychologic effects included paranoia (46%), sleep disturbance (18%), and tolerance to cocaine requiring increasing amounts of cocaine to cause the same level of intoxication (25%). After being in the rehabilitation program for 1 month, 93% of the group were still experiencing cocaine craving, the majority describing this as "severe." Social withdrawal was described as loss of close friends (14%) and serious conflicts (18%). Eighty-six percent described running away to avoid conflict at home, and 68% had stayed away more than 1 week.

A limited comparison of the teenagers admitting to heavy cocaine use with those who denied cocaine use showed that the cocaine-using adolescents spent more money obtaining drugs. Cocaine users reported a shorter duration between cocaine initiation and weekly use compared to the experience of non-cocaine users with their drug of addiction.

DISCUSSION

Experimentation and taking risks are normal learning behaviors for adolescents. They enjoy a sense of invulnerability and frequently lack insight into the consequences of their behavior. However, this time of transition is largely ignored by society, and teenagers experience strong social pressures.[11] Substance abuse is a definite consequence. Involvement with cocaine is particularly devastating because of its addictiveness. This is confirmed in this survey by the rapid progression from the onset of cocaine use to dependence, occurring within weeks, and its accompanying social deterioration. Of much concern is the duration of time taken to initiate treatment after the family acknowledged the teenager's problem with chemical dependancy. Already involved therapists also failed to notice or respond appropriately.

This study involved only small numbers of a discrete group of teenagers. We cannot know how this information may relate to other groups; generalization is not possible. However, there is a lack of information concerning heavy cocaine use in the school-aged population. This study begins to address this void, and the results at least highlight the severity and extent of chemical dependency in some adolescents.

Older adolescents are now more likely than previously to perceive greater risks with regular cocaine use and to disapprove even of experimenting with cocaine.[2] However, the prevalence of cocaine use has remained constant throughout the past 6 years.[2] Of much interest is why some adolescents initiate substance abuse. As with all adolescent health problems, it is probable that the causes are directly related to social, economic, and social welfare policy.[12] The teenagers surveyed described themselves as being depressed and having school difficulties before starting drug use, problems that only escalated after they were chemically dependent. Psychosocial antecedents have been described in other studies[9] and in association with teenage smoking behavior.[13,14]

Surveys of smoking behavior also stress the importance of the availability of cigarettes,[14,15] adult and peer approval and models,[13-15] and the lack of perceived health risks.[15] Smoking and substance abuse are perhaps part of a syndrome of adolescent problem behaviors.[16] In a survey of a homogeneous adolescent population, significant correlation was found between the level of substance abuse and destructive coping behavior, risk-taking behaviors, and school performance. In this group, social environmental factors were the strongest influence on substance use.[16] The results from the smoking surveys suggest that different factors are important for different racial and socioeconomic groups.[13-16]

Of much concern is the risk of adolescent behaviors leading to infection with the human immunodeficiency virus (HIV). There is a recognized association of HIV infection with the sharing of contaminated needles; however, the teenagers surveyed were not intravenous drug users. Prostitution was reported; this is certainly a risky behavior, as is any sexual intercourse if condoms are not used and particularly if anal penetration occurs. In addition, the sexual partners of drug-abusing teenagers may themselves be intravenous drug users. Preliminary testing of Straight clients has not yielded positive HIV results; this testing included 16 members of this study group. However, with the increasing prevalence of HIV seropositivity, these teenagers will be at significant risk of acquiring HIV infection.

Pediatricians involved with the medical care of adolescents must be alert to the possibility of chemical dependency including cocaine abuse in their patients. Cocaine is available to teenagers, and addiction is devastating. Few symptoms were evident in the surveyed cocaine users, but in common with other drug users, social withdrawal and dysfunction were almost universal. Evaluation of such problems as school truancy or failure, social isolation, or increasing family conflicts must include a consideration of drug dependency. This consideration is also most important when assessing the health needs of runaways, delinquents, and other teenagers who violate laws.

Prevention of substance use remains essential to protect adolescents.[7] This must involve education and awareness of the psychosocial risk factors with available early intervention. A strong focus on skills training for resisting social influences has been emphasized.[16] All such measures must be implemented in elementary school given the young age at which substance use is initiated.

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ACUTE CASES OF SYDENHAM CHOREA SOUGHT

The Child Psychiatry Branch of the National Institute of Mental Health is seeking patients for a study of obsessive compulsive symptoms accompanying Sydenham chorea. Eligible patients should have had *recent* (within 2 months) onset of Sydenham chorea, continue to have choreic symptoms and be at least 6 years of age. This study will rate obsessive compulsive symptoms and link these symptoms to anti-CNS autoantibodies. Patients will be interviewed by phone or in person (out of town subjects will be asked to travel at our expense to the NIH in Bethesda). Brief follow-up interviews will be conducted every 2 months for 1 year. Serum samples (5 mL) will be obtained on four separate occasions. There will be no expense to the patient and no remuneration. Please call (301) 496–6081 or write: Dr Susan E. Swedo or Dr Judith L. Rapoport; Child Psychiatry Branch, NIMH, Bldg 10, Room 6N240, 9000 Rockville Pike, Bethesda, MD 20892.

HOSPITAL PHYSICIAN

Cocaine Intoxication:

A Review of the Presentation and Treatment of Medical Complications

James F. Buchanan, PharmD

The increased popularity of cocaine in recent years has led to an increase in the incidence of medical complications associated with this drug. The range and severity of potential toxicologic effects vary greatly and require the physician to be familiar with both the pharmacology of the drug in its various forms and the therapeutic options available in the treatment of overdose.

The psychoactive properties of cocaine have probably been recognized since at least 600 AD.[1] Since that time, cocaine has been used in a variety of forms and routes of administration. Recently, smoking alkaloidal cocaine has become a popular mode of recreational use.[2] The subjective feelings of intoxication and the profile of adverse reactions associated with smoking cocaine differ from those associated with intranasal use. These differences, as well as the physical characteristics of alkaloidal cocaine, are frequently a source of confusion to both the health care professional and the lay public.

Until recently, snorting powdered cocaine hydrochloride was the preferred means of self-administration. Contact with the nasal mucosa causes immediate local vasoconstriction, which limits the rate of drug absorption and, presumably, drug toxicity. Although complications from intranasal use have been reported, the frequency of these adverse effects is sufficiently low to give this method of cocaine use the reputation of relative safety. Persons at particular risk from intranasal use appear to be those who administer the drug repeatedly, resulting in high cumulative doses.

The pharmacokinetics associated with inhalation of volatilized cocaine are similar to those seen with intravenous (IV) use of the drug. High serum, myocardial, and CNS concentrations of cocaine are rapidly achieved, with an attendant high risk for untoward complications. Since the popularization of cocaine smoking, the incidence of myocardial ischemia, hypertensive episodes, and seizures has greatly increased.

The intensity of the euphoria associated with smoking cocaine is significantly greater than that associated with intranasal use, but it is also of shorter duration. This may result in the use of larger quantities of cocaine and in greater frequency of administration to maintain intoxication. Such a pattern of use is associated with a high potential for dependency and overdose.

To effectively smoke cocaine, the alkaloidal (free-base) form must be used (see *box*). The free base is volatile (sublimation) at temperatures of 90 °C, whereas the melting point of cocaine hydrochloride is 195 °C, at which point it tends to decompose rather than volatilize.

Pharmacologic Properties

Cocaine acts as a local anesthetic and an indirect sympathomimetic.[4] The anesthetic effect is due to the ability of cocaine to block initiation and conduction of electrical impulses in nerve cells. The sympathomimetic effect arises from the blockage of presynaptic reuptake of the neurotransmitters norepinephrine and dopamine. Accumulation of neurotransmitters at postsynaptic sites results in sympathetic stimulation that is characterized by tachycardia, hypertension, seizures, hyperthermia, and general CNS stimulation. The increased stimulation of dopaminergic neurons is believed to be responsible for producing euphoria.[1]

Biotransformation of cocaine is primarily by plasma and hepatic cholinesterases.[7] Cholinesterase activity is reduced in infants, geriatric patients, pregnant women, and patients with liver disease or congenital cholinester-

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ase deficiency; therefore, these types of patients would be expected to be more sensitive to the pharmacologic effects of cocaine.

The serum half-life of cocaine is approximately one hour. Since the drug disappears from the circulation so rapidly, it is not practical to measure cocaine serum concentrations. Benzoylecgonine, the major metabolic product, is the moiety measured in toxicologic analysis; it can be detected in serum or, more reliably, in urine for up to two to three days after cocaine use.

Toxicologic Effects

Cardiovascular

Cocaine's inhibition of catecholamine reuptake by sympathetic nerve endings produces general sympathetic stimulation. Cardiovascular manifestations are typified by tachycardia and hypertension. Cocaine use may result in significant coronary artery vasoconstriction with resulting ischemia or infarction. Sinus and ventricular arrhythmias may occur from an ischemic process or from excessive catecholamine stimulation.

Sinus tachycardia generally does not require intervention unless the ventricular rate is excessive, particularly in the case where it is too fast to maintain adequate cardiac output. In such cases, propranolol or esmolol may be administered to reduce the tachycardia. (Propranolol, 0.5 to 1.0 mg IV, repeat every one to two minutes prn to 0.1 to 0.15 mg/kg maximum; esmolol, 500 µg/kg IV over one minute, then 50 µg/kg/min infusion, titrated incrementally by 50 µg/kg/min every five minutes prn, 300 µg/kg/minute maximum.)

Hypertension is best treated with the use of vasodilators such as nifedipine (10-mg capsule punctured and chewed), phentolamine (5 mg IV), or nitroprusside (3 µg/kg/min infusion, titrated). Propranolol, purported to be an antidote for cocaine intoxication,[8] is best reserved to treat only tachycardia. Use of beta-blocking agents in the face of elevated levels of norepinephrine will result in unopposed alpha-receptor stimulation; this can, paradoxically, worsen hypertension.[9,10]

Premature ventricular contractions and ventricular tachycardia may be treated with the use of beta-blocking agents or lidocaine. Ventricular fibrillation and asystole have been described as complications of cocaine abuse.[11] Epinephrine and norepinephrine should be used cautiously in this setting since cocaine will potentiate their adrenergic effects.

Angina, myocardial ischemia, and infarction are recognized complications of IV and intranasal cocaine use[12-16] and, more recently, from smoking free-base cocaine. Both coronary artery vasoconstriction and increased cardiac oxygen demand are believed to contribute to the ischemic process. Patients having chest pain and ECG evidence of ischemia should be admitted for evaluation and serum enzyme studies. Nitrates or calcium channel blockers are effective in reversing coronary artery vasospasm. Calcium antagonists may also be protective against the cardiotoxic effects of cocaine intoxication.[17]

Neurologic

Nominal doses of cocaine, either snorted or smoked, produce euphoric feelings. Excessive acute or cumulative quantities of cocaine result in anxiety, agitation, paranoia, and seizures. The anesthetic action of cocaine, possibly coupled with cerebral ischemia, can produce coma when large amounts of the drug are taken. The depres-

Free-Base Form

The current popularity of smoking free-base cocaine probably arose as the result of a linguistic misunderstanding.[3] In the illicit processing of coca leaves, a precipitate of crude, extractable alkaloids, known as cocaine paste or base, is produced. In Spanish, this paste or base is referred to as *base* (pronounced BAH-SAY). It is subsequently processed to cocaine hydrochloride, but can also be smoked as a mixture with tobacco or marijuana. North American visitors to South America, observing the smoking of *base*, mistakenly thought it referred to "free-base" cocaine. Smoking free-base cocaine was heretofore unknown among traditional *base* or paste smokers of South America.

The conversion of cocaine hydrochloride to free-base cocaine has been advocated as a means to "purify" the cocaine. Street cocaine frequently contains a variety of active adulterants (eg, lidocaine, procaine, benzocaine, phenylpropanolamine, ephedrine) and inactive adulterants (eg, lactose, sucrose, mannitol, starch, talc).[4] Some of these substances are not removed by the extraction process of converting cocaine hydrochloride to the free-base form. Significant amounts of lidocaine, ephedrine, procaine, benzocaine, and phenylpropanolamine are recovered along with alkaloidal cocaine following extraction.[3]

Crack is free-base cocaine in a crystalline or "rock" form rather than a powder. It is typically sold in small vials containing 100 to 300 mg of alkaloidal cocaine at a cost of $5 to $10 per 100 mg.[5] The "rocks" are placed in a pipe or on a piece of foil and heated to vaporization. Crack may also be smoked in tobacco or marijuana cigarettes. The name "crack" originated from the popping sound that frequently occurs when the substance is heated. Euphoric effects occur within seconds of inhalation but last only about 20 minutes, necessitating frequent administration to maintain the euphoria.

Table 1
Pharmacokinetic Differences Between Intranasal, Inhaled, and Oral Cocaine Use

Type of cocaine	Intranasal Cocaine hydro-chloride	Inhaled Alkaloidal (free base)	Oral Cocaine hydro-chloride
Onset	5–20 min	Seconds	20–60 min*
Duration of euphoria	1–1.5 h	About 20 min	1-2 h
Serum half-life	1 h	1 h	1 h

*Onset of effect following ingestion of alkaloidal cocaine may be delayed owing to its poor solubility.

sant effect of cocaine in such circumstances may result in respiratory depression or arrest.

Seizures are most frequently encountered after IV administration or inhalation of cocaine[18]; convulsions rarely result from intranasal use. Inhalation of cocaine produces a rapid rise in the serum concentration of the drug almost identical to that which occurs with IV administration. The rapid presentation of cocaine to the CNS may produce seizures shortly after exposure. Cocaine first stimulates the cerebral cortex by blocking the reuptake of norepinephrine and dopamine, which is believed to produce the seizure activity, and then produces a generalized depression of cerebral and brainstem function.

Cocaine-induced seizures are usually transient in nature and require no therapy. Overdoses of cocaine, however, may be associated with persistent seizure activity and can progress to further complications, such as metabolic acidosis, hyperthermia, and rhabdomyolysis. Diazepam (5 to 10 mg IV over two to three minutes, repeat every ten to 15 minutes prn to 30 mg) is considered the drug of choice to terminate seizures produced by cocaine. Benzodiazepines are also useful to control symptoms of anxiety and agitation.

Cocaine is believed to cause vasospasm of the cerebral vasculature. The attendant rise in intracranial blood pressure has produced subarachnoid hemorrhage in patients who snort the drug.[19,20] Intracranial hemorrhage from intranasal cocaine use is probably a rare event most likely to occur in persons with preexisting arteriovenous malformation or aneurysm.[21] The finding of headache or any focal neurologic deficit following cocaine use should alert the clinician to the possibility of intracranial hemorrhage.

Arterial vasospasm may also result in cerebral infarction following intranasal cocaine use[22] or smoking of the free-base form.[23] Cerebral infarction has been described in a neonate whose mother used large amounts of cocaine prior to delivery.[24]

Respiratory Tract

The local vasoconstriction accompanying topical application of cocaine can produce local tissue ischemia, particularly in the nasal mucosa following insufflation. Chronic snorting of cocaine has been associated with nasoseptal necrosis and perforation.

Pulmonary injury infrequently occurs because of drug exposure; however, several reports demonstrate an association with the use of free-base cocaine. Pneumomediastinum,[25-27] pneumothorax,[25] and pneumopericardium[28] have been described as consequences of smoking alkaloidal cocaine. The mechanism by which this occurs is unclear but may be related to increased intra-alveolar pressure from Valsalva maneuvers, direct alveolar damage, or both.

Studies of pulmonary function in cocaine smokers have revealed a reduced capacity for gas exchange without an impairment in ventilatory function.[29,30] This may be due to a direct toxic effect on the alveoli or may be caused by constriction of the pulmonary vasculature, thus impairing perfusion and possibly leading to alveolar rupture.

The finding of headache or any focal neurologic deficit following cocaine use should alert the clinician to the possibility of intracranial hemorrhage.

The air released from distended, ruptured alveoli tends to track to areas of lower pressure such as the mediastinum. If mediastinal pressure is high, air will dissect along fascial planes, resulting in pneumothorax. Patients having pneumomediastinum typically complain of chest pain. Mediastinal crepitus (Hamman's sign) may be present in roughly half of such cases. In the majority of cases, pneumomediastinum resolves spontaneously without treatment. Chest films generally show a return to normal within two to three days. Despite a history of smoking cocaine in a patient with pneumomediastinum, other causes such as infection, tumor, foreign body, or esophageal perforation need to be ruled out.

Metabolic

Hyperthermia plays a significant role in fatal cocaine intoxication.[31] Cocaine, like any other stimulant drug, can produce hyperthermia from increased muscle activity, seizures, and vasoconstriction-induced impaired heat dissipation. Cocaine may also act as a pyrogen by directly affecting the hypothalamic thermoregulatory centers. Of key importance is the rapid detection and management of hyperthermia in severely intoxicated patients. Rectal temperature should be measured; because of vasoconstriction, oral or axillary temperature may not reflect core temperature. External cooling measures, such as application of cool water and fanning, should be promptly instituted. Muscle paralysis with pancuronium (0.08 to 0.1 mg IV) or vecuronium (0.08 to 0.1 mg/kg IV, followed by 0.03 to 0.05 mg/kg every 20 to 30 minutes) may be indicated if external cooling measures are ineffective in the presence of muscular hyperactivity. Seizures should be controlled with standard anticonvulsants, eg, diazepam (see section on neurologic effects). In severe cases refractory to these measures, dantrolene may be tried.

Gastrointestinal

Contrary to generally accepted belief, cocaine is well absorbed from the gastrointestinal (GI) tract.[13] Peak plasma concentrations occur 20 to 60 minutes after ingestion, producing a euphoric effect similar to that associated with intranasal use. Thus, significant systemic effects can occur following recreational oral use and overdose, particularly in the cocaine "body-packer" syndrome.

One method of smuggling cocaine (body packing) is to ingest packets wrapped in condoms, plastic food wrap, or various other materials.[31,33] Occasionally, these packets rupture, releasing large quantities of cocaine. Seizures, hypertensive crisis, hyperthermia, and death can result.

Patients suspected of ingesting cocaine packets should be examined with the use of abdominal roentgenography. The packets may be partially radiopaque or may

Table 2
Cocaine-Induced Complications and Recommended Treatment Approaches*

Organ System	Adverse Effect	Treatment
Cardiovascular	Sinus tachycardia	Propranolol, esmolol
	Hypertension	Nifedipine, phentolamine, nitroprusside
	Ventricular tachycardia	Lidocaine, propranolol
	Angina	Calcium-channel antagonists, nitrates
Neurologic	Agitation	Diazepam
	Seizures	Diazepam
Metabolic	Hyperthermia	External cooling, paralysis, dantrolene
Pulmonary	Pneumomediastinum	Supportive care
	Pneumothorax	Supportive care
Gastrointestinal	Nausea, diarrhea	Supportive care
	Intestinal ischemia	Vasodilators

*See text for discussion of treatment recommendations.

be identified by gas halos, depending on the packaging material. Activated charcoal and sorbitol should be administered to absorb released cocaine and to facilitate expulsion. Because intestinal stimulation may compromise the integrity of the packets, stimulant laxatives should be avoided. It is important to monitor patients for symptoms of cocaine intoxication and GI obstruction until the packets are expelled. Surgical removal should be reserved for cases of GI obstruction or serious intoxication from unexpelled packets.

Both inhalation and oral use of cocaine have been associated with intestinal ischemia, ranging from diarrhea to intestinal gangrene.[34,35] In my experience, diffuse abdominal pain and nausea is a not-infrequent complaint among recreational cocaine users. Intestinal ischemia is believed to be caused by alpha-receptor-mediated vasoconstriction in response to increased levels of norepinephrine. Theoretically, in severe cases this effect could be reversed by alpha-blocking drugs, such as phentolamine, or other vasodilators (eg, nifedipine).

Gastrointestinal upset and diarrhea associated with cocaine use are usually self-limiting. The clinician should be aware of more serious signs of intestinal ischemia. Abdominal distention, rigidity, absent bowel sounds, and marked leukocytosis indicate possible bowel ischemia or infarct and may necessitate surgical and pharmacologic intervention.

Hepatic

It has been hypothesized that cocaine may cause hepatotoxicity in humans,[36] but this theory has yet to be proved. Animal data, however, implicate cocaine as a potent hepatotoxin.[36-37]

Greater than 90% of cocaine is metabolized by hydrolytic reactions; only 10% or less undergoes oxidative metabolism. In animal models the development of hepatotoxicity was ascribed to the oxidative products norcocaine and *N*-hydroxynorcocaine.[38] It remains unclear if these compounds are directly hepatotoxic or if toxicity is mediated by a loss of cellular-reducing equivalents.

Based upon these observations, it has been proposed that individuals with glucose-6-phosphate dehydrogenase (G6PD) deficiency may be more prone to the possible hepatotoxic effects of cocaine.[38] Additionally, persons with decreased plasma pseudocholinesterase activity would depend more upon oxidative systems for metabolism and, thus, may produce more hepatotoxic products. Further research is needed to delineate the significance of the hepatotoxic potential of cocaine in humans.

Gynecologic

A general increase in the use of cocaine among obstetric patients has recently been noted. A study of eight infants born to cocaine-using mothers noted no serious withdrawal reactions or teratogenic effects.[39] The authors concede that withdrawal effects may be too subtle to discern in this small patient population. Further developmental studies are needed to assess potential long-term effects. Other investigators contend that maternal cocaine use is associated with a higher incidence of congenital malformations.[40]

Cocaine use has been implicated in occurrences of abruptio placentae.[41] It has been hypothesized that in such cases, transient hypertension and possible placental vasoconstriction induce uterine contractions. Women who use cocaine during pregnancy exhibit an increased risk for spontaneous abortion.

Conclusion

The increased incidence of cocaine-related medical problems, which has paralleled the rise in the popularity of cocaine, is expected to continue to escalate with the recent popularity of free-base cocaine or "crack." It is important for the clinician to recognize not only the toxicologic consequences of cocaine use in general, but also the potential differences in the pattern of symptoms associated with inhaled versus insufflated cocaine. The appropriate treatment of cocaine intoxication and the avoidance of iatrogenic complications require an understanding of the pharmacology of cocaine and of the drugs used to manage cocaine toxicity. ☐

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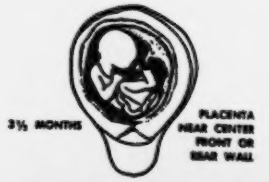
continued

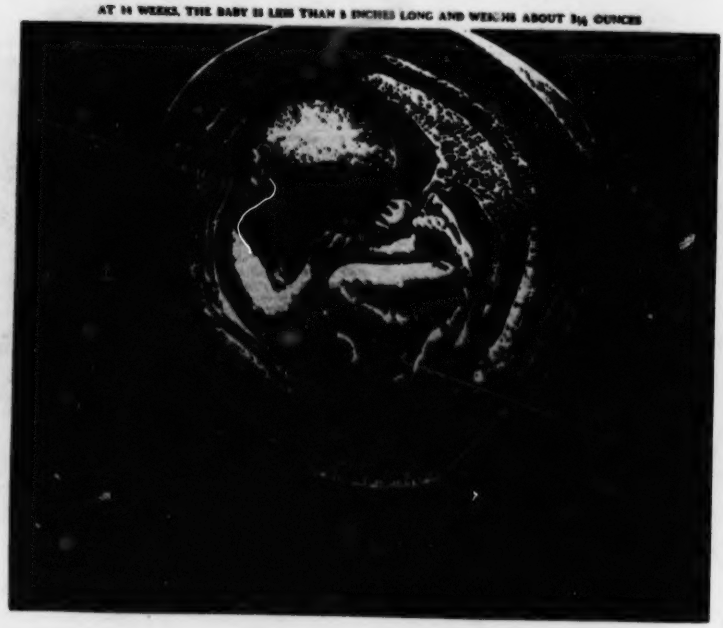
Developing Baby at 14 Weeks



AS WE LOOK at this picture – the baby at three and one-half months – we are aware of the miracle of growth. Since the baby occupies the whole capacity of the uterus, the uterine wall begins to stretch as it continues to grow. This ability of the uterine wall to stretch provides the baby with sufficient space for his exercise and growth needs. The artist has shown the two membranes, the chorion (the outer) and the amnion (the inner), which form the amniotic sac.

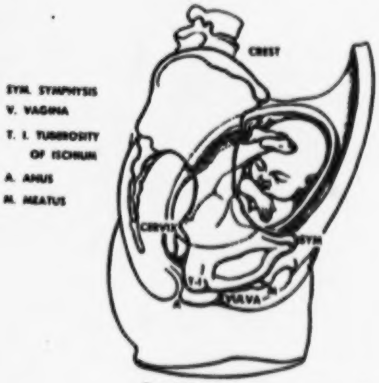
The placenta is now well developed. Through it flows the mother's bloodstream, bringing food and oxygen for the baby. The baby's heart pumps his blood to and from the placenta by way of the blood vessels in the umbilical cord. If we could look inside the cord, we would see three blood vessels – one large vein carrying blood with oxygen and nutrients to the baby, and two smaller arteries carrying blood with carbon

AT 14 WEEKS, THE BABY IS LESS THAN 5 INCHES LONG AND WEIGHS ABOUT 3¼ OUNCES



dioxide and other waste products from the baby to the placenta. These three vessels are encased in a pale blue-green gelatinous substance and the whole structure is covered by a thin shining membrane.

In the placenta, on the way from the umbilical arteries to the vein, the baby's blood with its cargo of waste products flows through tiny thin-walled capillaries that are surrounded by little pools of mother's blood. As the baby's blood is moving through these capillaries, the food and oxygen in the mother's blood exchange places with the waste products in the baby's blood by passing through the capillary walls in opposite directions. The baby's waste is then eliminated together with the mother's waste, as her blood flows through her kidneys, skin and lungs. The food and oxygen are carried by the baby's bloodstream to every cell in his body where they are exchanged for the waste products of the cells' activities. The mother's blood does not normally mingle with the baby's, nor his with hers. The two circulations are completely separate.



The baby at about 5 months can be seen protected by the bony framework of his mother's pelvis – but as he grows, the uterus extends upward into his mother's abdomen without disturbing her body's normal functions.

CURRICULUM VITAE

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Chairman MILLER. Dr. Halfon.

STATEMENT OF NEAL HALFON, M.D., M.P.H., DIRECTOR, CENTER FOR THE VULNERABLE CHILD, OAKLAND CHILDREN'S HOSPITAL, OAKLAND, CA; AND ASSISTANT CLINICAL PROFESSOR OF PEDIATRICS AND HEALTH POLICY, DEPARTMENT OF PEDIATRICS AND INSTITUTE FOR POLICY STUDIES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Dr. HALFON. Congressman Miller and other members of the committee, I want to thank you for asking me to address you today. I'm director for the Center on the Vulnerable Child at Children's Hospital in Oakland. I'm a practicing pediatrician and my practice largely deals with foster children. About half of the 300 kids that I'm now taking care of have been drug exposed.

In addition, the Center for the Vulnerable Child is a research center that is trying to develop new clinical service programs not only for foster children but for drug-exposed babies, young teen parents, and trying to study the long-term effects and policy implications of these kinds of problems.

I would like to briefly give you an overview about the prevalence and trends of crack cocaine exposure and try to talk more directly about the impacts of crack cocaine use on the health care and child welfare systems.

I think that one thing that needs to be remembered is that the exposure estimates that we're hearing, for example the 11 percent estimate that was generated from the Chasnoff study of 36 hospitals across the United States, had a range of 0.4 percent to 27 percent. That's quite a range to explain when you are doing a study. The reason why there was such a broad range is that hospitals that are looking for crack cocaine users are finding it. Those that are not looking for it are not finding it.

We know that even the best reporting using urine toxicological screens and/or self reports are vastly underestimating the problem. I think we need to take these estimates with a few grains of salt and realize the magnitude of the problem is greater than what we're actually hearing.

Second, the trends are increasing everywhere across the country and most urban hospitals in California are reporting 10 to 25 percent of all babies born being drug exposed, mostly due to crack cocaine. Again, that's usually determined through urine tox screens and I bet we're missing about half of those actually exposed some time during the pregnancy.

This trend is demonstrated, for example, in Oakland; the Highland General Hospital reports that in the past two years there has been an 84 percent increase in drug exposed babies. Highland is up to about 16 to 20 percent of all births being born exposed.

I have attempted to make a more conservative estimate than Dr. Chasnoff did using statistics from our Office of Statewide Health Planning and development which are presented in my prepared statement. I estimate that this year there would be somewhere between 17,000 and 31,000 babies born that were cocaine exposed in California which is consistent with Chasnoff's estimate of 375,000 since approximately 1 in 9 babies are currently born in California.

Other witnesses and Congressman Miller alluded to the impacts of crack cocaine during the perinatal period, including prematurity and abruption of the placenta, reduced brain growth, intrauterine growth retardation, congenital malformations of the heart and urinary tract, and the transmission of H.I.V.

Part of my frustration is that we know that when you intervene early in these women's lives and get them into prenatal care you can actually halt some of these adverse effects. Chasnoff and Northwestern Group reported in the Journal of the American Medical Association that when early interventions were mounted, and the crack cocaine use was stopped during the first trimester of pregnancy, they were able to reduce the risk of prematurity and intrauterine growth retardation. That tells us that prenatal care and early interventions have an effect.

Some post-natal sequellae have also been suggested by other witnesses. These include: irritability, movement and sleep disorders, altered state regulation, fine motor deficits, continued emotional lability, poor attachment to caretakers, distractability, cognitive difficulty in toddlers and persistent emotional cognitive delays in the schools years.

I'll warn you that there actually aren't many studies that have been published at this time, following children past the early infancy and toddler stage so that further conjectures are based on anecdotal data. Although I think these potential problems are bad and there are lasting implications my other great frustration is that I know that the drug exposed babies that are placed back into a home with a biological mother who isn't getting services or into a foster home with a foster parent who isn't getting services are likely to end up having continued emotional and cognitive delays.

I know from the work at our program that kids that get services are able to be helped.

I also want to mention the impacts on the child welfare system. As many as 60 percent of drug-exposed infants are placed into foster care, and the dramatic increase of crack cocaine use is mirrored by the increased number of foster children. Throughout the nation from the late 70's to early 80's we actually saw a decreased number of kids in the child welfare system. In California, from 1982 on we have witnessed a half percent increase per month in the child welfare system.

From 1986 to 1988 there has been a 28 percent increase from 49,000 to 64,000 children in foster care. When we look at who these kids are, these are babies who are drug-exposed. Los Angeles County has reported over 1000 percent increase from 1982 to 1987 of babies being placed in the child welfare system because of drug exposure. When we look at data for the State of California, we see the flooding of the foster care system leading to 30 percent longer stays, meaning that kids are staying longer in foster care. This impacts all kids, since the system is completely overloaded. Thirty percent of the kids now in the foster care system are less than 5 years of age and in some counties 70 to 80 percent of all kids coming in under 2 years of age are drug exposed. That is the case in Alameda and Contra Costa Counties.

There are other important impacts on health care costs. There was a study done in Los Angeles County that looked at 915 drug exposed infants. Postnatal hospitalization for those 915 infants cost $32 million in 1986. If 70 percent of those 915 babies were born at term, but had longer hospital stays up to about 9 days because of perinatal complications. The average costs for those babies was $5,400. Twelve percent of those babies were born premature with no complications. Their average hospital stay was 45 days at an average hospital cost per day of $1,500, or about $63,000 per baby. And 18 percent of those babies were born premature with complications, 90 hospital days, $1,500 a day and at a cost of $135,000 per baby.

That's how that $32 million figure was generated. If we take the state of California and use my conservative estimates of 16 to 30,000 babies born this year, we're talking about $500 million to $1 billion of hospital costs in the neonatal period for these babies. This does not include what the additional health care costs for those kids are, the special education costs, the foster care costs, the remedial resource costs for these kids.

I've included in my written testimony some emphasis on the kinds of programs that are addressing this kind of problem. There are programs currently in New York City, in Los Angeles, in Chicago, in Philadelphia and in Oakland that try to address these problems.

Not only are the babies needy but the mothers are very needy. If we're going to address this problem in a rational way the preventive and prenatal efforts have to be very intense and we have to provide a continuum of care for these women and for their babies. Any gap in the system is a gap that these women will fall through.

I've provided for you in my written statement a continuum service model that we have proposed in the Bay Area that includes prenatal care, perinatal care and post natal care for mothers and children. This is comprehensive, continuous care, that has to be intensive if we're going to effect this problem.

Since half of these kids are going into foster care, and if we have any desire to try to reunify families, we need more foster mothers because we have overcrowded foster homes at the present time, where five, six babies are being placed into one foster home. These foster mothers are not able to get medical services, health services, developmental services, parent/infant services that they need to be able to maintain these children.

Furthermore, attempts to reunify families have to provide the biological mother with the kind of support service that allows her to reunify. We don't have those kinds of services. Actually, Contra Costa County is one of the few places that has a small pilot program that tries to bring mothers together with their babies and foster mothers to smooth the transition. If you take a baby away from a mother for six months or two years while you're putting her in a nonexistent drug treatment program and then think that you can bring them back together and there can be any kind of meaningful relationship, you're absolutely wrong.

The young baby is going to start to fall in love with and bond to whoever the care taker is. If they have no contact with their biological mother we can basically forget it and we should be passing laws that terminate parental rights at birth which is something that I strongly disagree with.

In fact, when we started the foster care clinic two years ago I was in agreement with Daniel Weinstein who was then the presiding juvenile court judge in San Francisco County, who was ruling that all babies born drug exposed were abused until proven otherwise and was removing them from the home. Over the last two years we have had the experience of keeping babies with their mothers, providing them with intensive services and the kind of support they need and showing that (1) we get the mothers off drugs and (2) that we can show a normal, natural bonding process. In that way the baby and the motherhood experience become therapeutic levers for both baby's and mom's recovery.

If we are going to provide comprehensive services for kids and mothers that include prevention, early identification, diagnosis and treatment, we have to provide these services across a variety of domains. It's not just their physical needs but it's their emotional, cognitive and family needs.

That's a tall order and made more difficult by our current system that is disorganized. The last matrix and diagram that I present in my written testimony, outlines all the federal programs that currently exist for children. And what we see is that under medical programs we have Title XIX, Title V, E.P.S.D.T., M.C.H. Block Grant, Primary Care Block Grant and under Psychosocial programs we have A.D.M. Block Grants, Public Law 94-142, 99-457. We have Title XIX services, Title XX. We have many programs. The problem is that neither the foster mother nor the drug-using mother without a degree in civil engineering and social work could ever get to these programs the way that they're currently organized.

I think that Congress has done a good job creating programs but we don't have the mechanism, the glue money and the case management on the local level to bring those programs together for the people that need them.

In fact, Medicaid case management was authorized by Congress in the 1986 Omnibus Budget Reconciliation Act. This authorization is not being used at all by, as far as I know, by any state in the country. I know that New York nor California are using those case management funds and that's important glue money to pull all these diverse programs together. There are several legislative and policy decisions that can be made right now to start to improve this problem, and I hope that you will start to work on it. I'd be happy to answer any questions.

Chairman MILLER. Thanks Neal.

[Prepared statement of Dr. Neal Halfon M.D., M.P.H., follows:]

Prepared Statement of Neal Halfon, M.D., M.P.H., Director, Center for the Vulnerable Child, Oakland Children's Hospital, Oakland, CA, Assistant Clinical Professor of Pediatrics and Health Policy, Department of Pediatrics and Institute for Policy Studies, University of California, San Francisco, CA

Summary

Prevalence and Trends

- The detection of crack cocaine use by self reports or urine toxicology screens of mothers and babies is inexact and probably underestimates actual use.
- A survey of 150,000 births in 36 hospitals across the country showed that 11% of births had positive toxicology screen for illicit substances.
- Urban public hospitals including those in Los Angeles, Oakland, and San Francisco are reporting 10-25% of births with positive urine toxicology screens; and screens may miss up to half of those exposed to drugs in-utero.
- The trend is increasing by all reports; such as an 84% increase in drug exposed babies born at Highland General Hospital, Oakland, in the past 2 years; and northern California, Kaiser Permanente Hospitals reporting a doubling drug exposure between 1987 and 1988.
- One national estimate suggests that approximately 375,000 babies will be born drug exposed in the United States this year. More conservative estimates for California would suggest 17,000 - 31,000 drug exposed births in 1988.

Impacts on Mothers and Children

- Direct effects of perinatal drug exposure include: abruption of the placenta; spontaneous abortion in 20 - 30% of cases; premature delivery, 20 - 40% cases; intrauterine growth retardation and reduced brain growth, anomalies and malformations of the heart and urinary tract, and strokes and cerebral infants. Associated risks include infection with HIV and other sexually transmitted diseases.

- Early interventions that curtail cocaine use in the first trimester decrease the risk of prematurity and intrauterine growth retardation.

- Postnatal sequelae of intrauterine cocaine exposure include:

  Irritability; movement and sleep disorders; altered state regulation and fine motor deficits in infancy; continued emotional lability; poor attachment to caretakers; distractability; cognitive difficulties as toddlers; and suggestion of persistent emotional and cognitive delays into the school years.

- Chemically dependent pregnant women and mothers have often been victimized for long periods of time, have a large number of health, social service and social support needs, and have special needs for assistance once their babies are born.

Impacts on the Child Welfare System

- As many as 60% of drug exposed infants have been placed into foster care, and the dramatic increase in crack cocaine use is mirrored by increases in the number of foster children. In California, the foster child population increased by 28% from December, 1986 (49,978) to December, 1988 (64,090).

- Los Angeles County has registered an 1100% increase in the placement of drug exposed infants and children between 1981 and 1987. In Alameda County nearly 70% of all families whose children were placed in foster care had histories of substance abuse.

- The flooding of the foster care system is leading to 30% longer stays, 30% increase in foster children less than 5 years old, and a dangerous overcrowding of foster homes.

Impacts on Health Care Cost

- Perinatal hospitalization costs for 915 infants born in Los Angeles County in 1986 were estimated to be $32 million. Extrapolating similar costs to California estimates 15,000 - 30,000 drug exposed infants this year, which would put hospital costs in the range of $500 million to $1 billion dollars.

- Additional health care costs derive from subsequent needed long term health care, foster care, special education and remedial services, and the social costs incurred from the loss of long term productivity and the extended drain on social resources.

Recommendations for Intervention Programs and Policy Options

- Programs must emphasize prevention strategies targeting at-risk adolescent girls and other high risk groups through aggressive community outreach.

- A comprehensive continuum of multidisciplinary services including outreach, prenatal health care, post natal health care, drug treatment, case management, education, and infant-parent and social support services should be provided.

- Programs must be intensive (long term, frequent contact with home based component), comprehensive (interdisciplinary with services at one site), coordinated (participation by health, social service and education agencies) and sensitive to the special needs of these vulnerable women and children (residential treatment).

- Special programs must be established to assist the overburdened child welfare system, including: recruitment, training and support of specialized foster homes; additional social work and support services; and programs that provide greater access for drug exposed foster children to high quality medical, mental health and developmental services.

- Research is needed on the long term impact of drug exposure on the health and development of children; comparisons between children raised in foster care to those supported in their biological homes; cost benefit analyses of the efficacy of various prevention strategies on health and social welfare cost.

Congressional Presentation

Chairman Miller and Members of the Committee:

Thank you for inviting me to address the Select Committee on the Prevalence and Impact of Perinatal Substance Abuse. I am a practicing pediatrician and Director of the Center for the Vulnerable Child (CVC), a multidisciplinary clinical service, research and policy center at the Children's Hospital in Oakland, California. The Center is dedicated to exploring the relationship between the social conditions of children and families and their health and developmental status. My comments are based on my own clinical experience caring for a large number of drug exposed foster children in our Foster Care Clinic; on our research on health and social service delivery systems; and on the experience that has been communicated to me by my colleagues at the CVC including Barbara Tittle, M.D. and Nika St. Claire, who run our special program for drug exposed babies and their mothers.

The use of drugs, and especially crack cocaine, by women during their childbearing years has become a problem with enormous consequences. Stopping the flow of drugs into communities and providing real options for young women - especially those living in persistent urban poverty - are central issues that must be addressed if the pernicious effects of drug use are to be eliminated. My frustration as a clinician comes from knowing that much can be done to prevent drug use by pregnant women, and to assist their infants and children. Real programs of proven efficacy can be marshalled to improve the lives of drug exposed babies living with their biological mothers as well as of those unfortunate children placed into the overburdened child welfare system.

My comments will address the magnitude of the problem, concentrating on the impact of crack cocaine use among women in their childbearing years, as well as the impact on the child, the family and the social welfare system. I will also suggest policy options that can begin to address this problem, with a particular emphasis on preventive strategies.

MAGNITUDE OF PROBLEM

Several recent studies have attempted to estimate drug exposure in infants born in urban hospitals. These surveys either measure the drug and its metabolites in the urine of the mother or child, or rely on the response of mothers to confidential interviews. Both these methods of ascertainment are obviously flawed: Cocaine is not detectable in urine samples 24-48 hours after use, intermittent users will probably be missed, and toxicology screens of newborns will be negative unless the mother used cocaine within a week of delivery. Self-reporting, even under the most confidential circumstances, always leads to under-reporting, and many pregnant women will deny use because they feel guilt at using the drug and fear that it will result in harm to the fetus. Furthermore, studies based on hospital deliveries will miss the increasing number of women dependent on crack cocaine and other drugs who do not seek prenatal care and who deliver their babies at home.

What is the prevalence of drug exposure in utero?

> Ira Chasnoff, M.D., of Northwestern University, surveyed 36 hospitals across the country (accounting for 150,000 births) and showed that 11% of births had positive toxicological screens for illicit drugs. The range of exposure was from 0.4 percent to 27 percent. This wide range was accounted for by the intensity of ascertainment, i.e., how hard hospitals looked for drug use. Of the nine hospitals that had conducted formal studies, crack cocaine was documented in 10-27 percent of all deliveries.

A prospective study conducted by Barry Zuckerman, M.D., and published in the March 1989 New England Journal of Medicine, indicated that 18 percent of all births at Boston City Hospital demonstrated cocaine exposure: half were detected by toxicological screen of the urine and half were detected via self-report by the mother. Relying just on self report would have missed over 30 percent of the exposures detected by urine analysis. A survey in Oakland in 1988 reported that sixteen percent of all births at Highland General Hospital, were positive for cocaine on toxicological screen.

Most urban hospitals in California now report that between ten and twenty percent of all births show evidence of drug exposure.

What are the trends?

There has been a shift in most urban public hospitals from drug exposure from heroin, PCP, and methamphetamines to drug exposure from cocaine.

In Oakland, drug exposed births at Highland General Hospital have increased 84 percent in the past two years, from 8.9 percent of births in 1986-87 to 16.4 percent of births in 1988.

Children's Hospital in Oakland reports that 20 percent of all babies transferred to the Neonatal Intensive Care Unit because of prematurity or other perinatal complications have evidence of drug exposure. This percentage represents a three-fold increase in the last two years.

Northern California Kaiser Permanente Medical Plan, which accounts for approximately a third of all deliveries in the Northern California/Bay Area region, reports a two-fold increase between 1987 and 1988 in all types of drug exposures. Although Kaiser still reports exposure in less than 1 percent of births, their mode of ascertainment represents surveillance according to obvious signs and symptoms and not a systematic screening of all births. This doubling of drug exposed infants in the Kaiser system, which largely serves a middle class working population, signals the potential increase in drug use by non-urban poor women.

Estimate of Potential Exposure in California Births

It is possible to calculate the number of children to be born this year exposed to illicit drugs in utero. Approximately 500,000 children are born in California each year, representing one out of every nine births in the United States. Data from the 1986 Hospital Facilities Commission indicate that approximately 135,000 births were paid for by Medi-Cal or other indigent services. Very conservative estimates assume:

1) illicit drug use in the non-poor population at .1 percent;
2) illicit drug use by other poor women not delivering in public hospitals is 5 percent;
3) illicit drug use by women delivering in the urban county hospitals is 15 percent.

Approximately 500,000 Births - 1987

65,000 Medi-Cal births at public hospitals x .15 =	9,750
70,000 Medi-Cal births at community hospitals x .05 =	3,500
365,000 non-Medi-Cal births at community hospitals x .01 =	3,650
	16,900

According to these conservative estimates, at least 16,900 children will be born in California this year exposed to illicit drugs, in particular crack cocaine. A more realistic estimate of drug exposure might place the Medi-Cal public hospital rate at 25%, the Medi-Cal community hospital rate at 10%, and the non-poor community hospital rate at 2%. Adjustment estimates in this range would suggest that almost 30,500 babies exposed to drugs will be born this year. Until more accurate surveillance is undertaken, these estimates will be only ballpark approximations. It should be noted that the 30,500 figure for California is consistent with Chasnoff's estimate that 375,000 babies will be born drug exposed this year in the United States.

Prenatal Effects

Cocaine and its metabolites increase the heart rate and blood pressure of the mother and decrease the supply of oxygen to the fetus through constriction of the blood supply to the placenta. Cocaine also is a strong appetite suppressant and can decrease essential weight gain, potentially hampering fetal nutrition.

Direct effects of perinatal drug exposure include:

-abruption of the placenta
-spontaneous abortion
-premature delivery
-intrauterine growth retardation
-anomalies and malformations
-strokes and cerebral infarcts

Associated effects include:

-HIV transmission
-STD transmission

A Chicago study indicates that babies of women who (because of intervention) use cocaine only during the first trimester do not necessarily escape all ill effects, but do display lower levels of prematurity, abruption, and no intrauterine growth retardation. The implications of the study are that early intervention and cessation of crack cocaine use in the first trimester can ameliorate many of the drug's effects and prevent other long term complications.

Post-natal Effects

The post-natal effects of intrauterine crack cocaine exposure are difficult to specify because of the influence of many other factors in the children's lives, including low socioeconomic status, environmental deprivation, family dysfunction, etc. Furthermore, since crack cocaine is a relatively new phenomenon, only a few studies have followed children for any period of time. Data are available on cocaine's effects on the first year of life, to a lesser extent on toddlers, and, to a much lesser extent, on pre-school and school aged children.

In infancy we find:

- irritability and hypersensitivity
- movement disorders and increased stiffness and tone
- altered state regulation (sleep/wake cycles)

- -fine motor deficits
- -increased incidence of Sudden Infant Death Syndrome (SIDS)

Toddlers exposed to crack often:

- -are irritable and display poor impulse control and less goal-directed behavior
- -are less securely attached to caretaker
- -are distractible and easily frustrated
- -have expressive language difficulties
- -demonstrate less free play
- -lack ability to self regulate

Pre-school-aged children demonstrate:

- -learning difficulties
- -language problems
- -continuation of toddler problems

School-aged children, about whom relatively little is known, appear to show persistent cognitive and emotional delays.

The Maternal and Family Context of Chemical Dependency and Exposure

A profile of pregnant women who use crack cocaine reveals that:

- they have been victims of physical, sexual, and emotional abuse as children and adults;
- drug use has become an unsuccessful coping style to deal with persistent exposure to violence including physical abuse and rape;
- a majority were raised in homes where one or both parents used drugs and/or alcohol;
- they are likely to live with a drug using partner and are often subjected to physical violence in these relationships;
- they need and have often been unsuccessful in receiving treatment for their chemical dependency and for both their biological and psychological signs and symptoms;
- they need housing, food, job training and education;
- they do not have access to or avail themselves of prenatal care;
- they have an increased prevalence of other medical and psychological problems including low self-esteem and social isolation;
- they are at increased risk for HIV infections secondary to IV drug use, prostitution and exchange of sex for drugs;
- they are at increased risk for other sexually transmitted diseases including syphilis, hepatitis B, and herpes;
- their use of drugs during pregnancy is complicated by complex, contradictory motivations and impulses;
- the compulsion to use drugs subordinates other health and welfare priorities to the acquisition of drugs;

- motherhood is often the only socially acceptable role that will mitigate pervasive feelings of low self esteem;

- they lack social support and networks that can help them seek treatment for their disease;

- chemical dependency treatment programs are not sensitive to the special needs of women;

- not only is the mother-infant dyad in jeopardy prior to birth, but in the post-natal period, as the child demands total commitment to his/her physical, developmental and emotional needs;

- a child's irritable temperament, fluctuating behavioral state, hypersensitivity and inconsolability is very demanding even for the most competent caretaker;

- mothers are confronted by Child Protective Services' challenge to their rights, custody, and ability to parent;

- a mother often has no place to live or must return to a residential setting with constant exposure to drugs as well as physical threats to herself and baby;

- mothers are often ignorant about infant care and developmental needs of the child; they have unrealistic expectations, especially given the baby's need for consistency and stability that may be in conflict with the mother's unstructured life;

- mothers need instruction and support in the care and enjoyment of the child, and confidence in the knowledge, skills, and qualities associated with good mothering.

Even given all the difficulties and potential problems, well designed comprehensive programs can provide mothers with resources to overcome their drug addiction illness and become adequate parents.

Impact on Foster Care System

Many drug exposed babies are placed into foster care at birth or in the first years of life. In some cases as many as 60% of drug exposed babies go into foster care. Recent studies report that increases in drug use are mirrored by statewide increases in the number of children entering the foster care system. Although foster care record keeping has been complicated by children's entry, exit, and re-entry into the foster care system, most authorities agree that the foster care population peaked in the late 1970's and was decreasing until about 1983. From 1983 to 1985, the foster care population in the state of California increased by approximately half a percent a month. If we were monitoring an infectious disease, this increase itself would be considered dramatic. The state Department of Social Services reports an even more dramatic 28 percent increase in the foster care population over the last two year period, with the number of open cases increasing from 49,978 in December of 1986 to 64,090 in December of 1988.

> Los Angeles County Children's Services reports a dramatic increase in drug exposure for children placed into foster care: In 1981, 241 cases of children placed were a result of drug use by parents; in 1987 this figure had risen to 1,437 (a 500 percent increase). In 1981, 132 children entered the foster care system because of drug withdrawal. In 1987, this figure was 1,619 (an increase of 1100 percent).
>
> In Alameda County, 68 percent of families whose children were placed in foster care during a four month period in 1987 had a family history of substance abuse. In 53 percent of cases, drugs and/or alcohol were the

> primary factor contributing to the removal of children. Similarly, in Contra Costa County, 56 percent of all child dependency cases involved parental drug use.

This flooding of the foster care system has other important ramifications for a system which was already overburdened and lacking sufficient resources. For example, from 1986 to 1988, the average stay in foster care increased 30 percent, from 15 months in 1986 to 20 months in 1988.

We also know that the foster child population has become younger, largely as a result of perinatal drug exposure and placement soon after birth.

> From 1985 to 1988, the percentage of foster children under 2 years of age increased by 30 percent and the number of children under 5 years of age increased by 23 percent. By 1988, over 32 percent of children in foster care were under 6 years of age.
>
> In Alameda County, 80 percent of all children in foster care less than one year of age had a history of drug exposure.

Whereas the number of foster children increased by 28 percent from 1986 to 1988, the number of foster family homes increased by only 11 percent. In other words, the rate of foster children entering the system is two and a half times the increase in new foster homes. With an increased demand for "good" foster homes capable of handling the special needs of drug exposed babies, and counties with different levels of reimbursement for foster care services, we are beginning to see competition between counties for special foster homes. For example, since San Francisco can pay more for foster homes, it is now "buying homes" in neighboring Alameda and Contra Costa Counties and eliminating potential foster homes for use by these communities.

The resultant crowding of children into foster homes is also mirrored in increased social work caseloads which make it difficult for social workers to attend to the needs of the child, to make thorough assessments and provide the services necessary to reunify families; or to move children to the best possible long term, and hopefully permanent, homes.

Many researchers, child advocates, foster parents, and social workers were already concerned about the foster care system before the recent influx of drug exposed children into the system. With the dramatic increase in this population of younger drug exposed babies entering overcrowded foster homes, an already bad situation is becoming disastrous. Profound emotional and developmental disabilities are likely if this highly needy population of drug exposed children does not receive essential support services.

Impact: Cost for Perinatal Health Services

Because of the prenatal effects of drug exposure and the fact that nearly 30 percent of infants exposed in utero are born premature, the increased costs in perinatal health services are dramatic:

> In Los Angeles County, 915 infants born in 1986 were estimated to cost $32 million because of extended hospital stays.
>
> 70% were term babies, hospitalized on average for 9 days, at $600/day, or $5,400/child.
>
> 12% were premature babies with uncomplicated courses hospitalized on average for 42 days at $1500/day, or $63,000/child.
>
> 18% born premature with complications were hospitalized on average for 90 days at $1500/day, or $135,000/child.
>
> Similar but smaller numbers are seen in Alameda County where in 1987, 48 severely ill premature babies born in Alameda County were transferred to the Neonatal Intensive Care Unit (NICU) at Children's Hospital in Oakland with an average length of stay of 41 days totaling 1,986 NICU days at an estimated cost of $2.6 million.

Rough estimates can be generated of the potential hospital cost for a projected population of 30,000 drug exposed infants born in California each year (roughly 5% of all births). Using the cost generated from the Los Angeles County study, assuming a prematurity rate of 30%, the cost for perinatal hospital care would exceed $1 billion. Since the rate of prematurity in some poor communities approaches 15%, this excess of 15 percent prematurity still would account for $500 million of hospital expenditures per year.

30,000 Births

.7 x 30,000 x 5,400 = $113 million
.12 x 30,000 x 63,000 = $227 million
.18 x 30,000 x 135,000 = $729 million
$1,069 million

Approaches and Intervention Strategies

For interventions to be effective they must not only address the symptoms and obvious effects of prenatal and post-natal drug exposure, but must also attempt to address the root causes of this destructive behavior. The causes of drug use are complex and are clearly tied to the conditions of persistent, urban poverty. Large segments of our population have no real alternatives to apparently attractive, albeit dangerous, drug subculture, especially when drug use becomes a coping mechanism for the pain and trauma of intrafamilial violence and abuse. Unfortunately, many of us are witnessing second and third generation drug and alcohol abusers and are caring for women who are delivering their fifth, sixth, and seventh drug exposed infant.

Most experts concur that pregnancy provides a window of opportunity for effective interventions into the lives of chemically dependent women. A wealth of experience has already been collected on the efficacy of early intervention programs aimed at other groups of high risk children, including those who are at risk because of prematurity, other perinatal complications, maternal mental illness and incapacity, and family dysfunction. Programs aimed at preventing medical, emotional, and cognitive problems in other high risk child populations can easily be adapted to meet the needs of drug exposed babies and their mothers.

Because chemically dependent women exist in a world of multiple risks and personal, psychic, and social disintegration, programs aimed at both mother and child must provide a continuum of services in order to be effective. Programs must be comprehensive, continuous, coordinated, timely and of high quality. We also know from research on prenatal care that programs which emphasize a continuum of prevention services are often more cost- and care-effective than costly treatment and rehabilitation services.

Examples of effective programs can be found in many cities across the country:

New York City: Center for Comprehensive Health Practice, New York Medical College

Los Angeles: the Eden Infant, Child and Family Development Center at Martin Luther King, Jr. General Hospital

Philadelphia: the Family Center, Thomas Jefferson Hospital

Chicago: the Center for Perinatal Addiction, Northwestern Hospital

Oakland: the Chemical Addiction Recovery Efforts Clinic (C.A.R.E.), Center for the Vulnerable Child, Children's Hospital.

Each one of these programs attempts to provide a comprehensive continuum of services that can include prenatal medical care, pediatric medical, developmental and psychological services, social services case management, chemical dependency treatment, parent education and training, home visits, mother infant counseling, childcare, drop in center, support group, hotline, drug free residential options, community outreach, and interagency collaboration.

Program staff emphasize the importance of offering flexible services including:

center based, home based, and community based programs with residential and day treatment options,

accessible services that respect the confidentiality of the client, so women can enter treatment without fear of criminal reprisals or the loss of their children to Child Protective Services,

programs that are collaborative, coordinated and multidisciplinary in order to coordinate the multiple service needs of women and their children and to avoid fragmentation.

Because clients in these programs are often psychologically vulnerable and suspicious of care givers, intervention programs also must be intensive and provide a strong supportive orientation. Development of a trusting, therapeutic relationship is the key first step to assist both mother and child. The important supportive roles such programs can play, including frequent contact, peer support and on going relationships are often the ingredients that can make the difference between addiction and recovery.

Figure 1 presents a comprehensive continuum care model for chemically dependent women, beginning in the pre-pregnancy stage followed by pregnancy, birth, the postpartum period, and the mother's relationship with the child. Six essential functions are identified that include prevention, early identification, diagnosis, treatment, rehabilitation, and case management. This matrix provides a way of assessing the level of comprehensiveness of the program. Any one box in this matrix can be filled with a variety of essential programs. For example, Preventive Services for pregnant chemically dependent women might include parent education, infant child health seminars, home management seminars, peer group support network, etc. Unfortunately, model programs are few and they are not well funded. Serious consideration must be given to the support, expansion and evaluation of such programs.

A full continuum of services for the chemically dependent women and child is outlined in Figure 2. These include comprehensive prenatal services, perinatal services, and postnatal services. Although we fundamentally believe that the mother-child relationship should be maintained if possible, often chemically dependent women are unable to care for their infants and/or abandon them and the children are placed into foster homes.

Two separate but mutually interacting postnatal pathways are outlined in this figure. Children leaving the hospital with their biological mothers demand a full continuum of center based and home based services that promote the infant mother relationship, parenting skills, and home management skills in the context of promoting the child's physical, emotional and cognitive development. Drug exposed babies in foster care need similar sorts of services. We cannot assume that foster parents can easily deal with the complex emotional, physical and cognitive problems that these infants pose. Furthermore, if real attempts are to be made to reunify families in keeping with Public Law 96-272, then constant mutual supportive interactions must take place between foster parents and biological parents around the care and nurturance of the child. Placing children into foster care with long periods of separation from their biological parents only serves to ensure future traumas for both mother and child.

At the Center for the Vulnerable Child, we have developed two model clinical service programs: the Chemical Addiction Recovery Efforts (C.A.R.E.) Clinic and the Foster

Care Clinic. Both programs provide comprehensive assessment of the child's physical, emotional and cognitive needs, as well as assessing family and social relationships of either the biological family or foster family. Our CARE clinic currently treats 25 mother infant pairs and will be expanding over the next several months in order to provide both home and center based services. The continuum of services is outlined in Figure 3.

The Foster Care Clinic provides similar comprehensive services and coordinated health care case management through the use of a multidisciplinary team as outlined in Figure 4. Although the Foster Care Clinic cares for foster children of all ages, approximately 50 percent of our 300 clients are infants and very young children with a history of drug exposure.

Providing comprehensive assessment and clinical evaluations of drug exposed babies is no easy task. Using the matrix presented in Figure 5, we have come to evaluate children in six separate domains. "Normal" children in a regular, middle class pediatric practice might have a problem in one or two of the boxes in this matrix. As the risk status of the child increases, the number of boxes with problems increases, as do the overall problems per box. For drug exposed babies, we are often confronted with a child with problems in every single box or cell of the matrix.

This poses very real delivery problems since each identifiable problem is often linked to a specific (and separate) service program.

The Matrix in Figure 6 uses a similar breakdown to demonstrate in a schematic way the different federal programs for which a child might be eligible. Matrix 2 reveals the real fragmentation that exists in federal programs aimed at meeting the needs of high risk children. One can imagine what it would be like for a marginally functioning chemically dependent woman with a host of needs and a real suspicion of government bureaucracy to be able to navigate all over town to receive the kinds of services to which she and her child might be entitled.

From a policy standpoint, this level of fragmentation confronting both the client and the service provider attempting to provide a continuum of comprehensive services can be overwhelming. Figure 7 shows that as the risk status of the population increases, that is, as the number of problems in the population increases, there is a need for increasing intensity and organization of services. For most children and families with a small number of problems, a primary care physician can adequately provide for the services necessary. As the number of problems increase, additional glue is needed to hold together the services.

Case management can provide this essential glue and brokering function, but even case management has its limits.

Policy Recommendations

1. Comprehensive, multidisciplinary prenatal services to women using drugs during pregnancy. Such a continuum of services would provide not only prenatal health care, but drug treatment, housing, job training, educational and support services necessary to support women attempting to rid themselves of a drug habit.

2. Perinatal and postnatal support services for chemically dependent women and their babies might include residential treatment facilities particularly designed for mothers and children, as well as additional support programs to facilitate both the development of the child and to support the healthy nurturance of the mother-child relationship. Such programs cannot be offered in isolation but must be integrally linked to drug rehabilitation and job programs, as well as to other coordinated and case managed services.

3. Support for the foster care system including additional social workers, recruitment of specialized foster homes, training for foster parents in the care of drug exposed babies, and special programs to provide infant development services.

4. Support services such as multidisciplinary service centers that can provide both the medical, developmental and psychological care needed by the drug exposed infant, and assistance to foster parents who are often confronted with a highly fragmented service system.

5. Provision of needed health care case management which would serve to help coordinate services and assist foster parents negotiation of the system. (This case management has already been approved through federal enabling legislation.)

6. Mandated coordination of available health and social service resources including: Crippled Children's Services (CCS); Early Periodic Screening Diagnosis and Treatment Programs (EPSDT), Developmental Disabilities services; special school based services available through Public Law 96-242 and Public Law 99-457.

7. Additional research funding to address important research and program evaluation issues.

An investment in these recommendations could reduce perinatal alcohol and drug use, eliminate or mitigate their impact on newborns and children, cut health care and social services costs, and improve the lives of thousands of women and their children.

APPENDIX I

CASE STUDIES

FOSTER CARE CONFERENCE

I. Case Study of CF

CF is now a 6-month old male who was born prematurely at 33 weeks weighing 2170 grams. CF's mother had 8 previous pregnancies, 3 live births, did not have prenatal care, and had a history of cocaine abuse. He was delivered by emergency C-section. He was hospitalized in an intensive care nursery and was discharged to a foster home at 3 weeks of age. Reasons for removal included: the positive tox. screen for cocaine; mother showed no interest in the baby and did not visit; mother was unable to provide appropriate arrangements after discharge; and her 3 previous children were in foster care. Over the next 3 to 5 months, he was plagued by persistent respiratory problems that include 2 episodes of pneumonia, chronic wheezing, and chronic rapid respirations. He has been hospitalized on two occasions for pneumonia and respiratory distress and was hospitalized most recently after a near-respiratory arrest. On this last hospitalization bronchoscopy revealed narrow floppy vocal cords as well as reflux of stomach contents into the respiratory tract. A new drug for reflux is not covered by Medi-Cal. Because of the reflux and floppy vocal chords he is eligible for CCS services.

Current home care requires the administration of bronchodilators via a home nebulizer as well as cardio respiratory monitoring. Although his care has become more routine, he has weekly appointments with one of several doctors. He has been maintained in out-of-home care because mother does not visit and has not been able to successfully participate in a chemical dependency program. At 6 months, his developmental status is somewhat delayed with problems in fine motor and gross motor functioning. He is bonding to his foster mother and shows good emotional attachment. The social worker reports that mother does not appear willing or able to resume care of this infant so that the child will be referred for potential foster-adopt placement.

Problems

1. Prematurity and drug-exposure
2. Rule out HIV infection
3. No maternal interest and need for long term placement
4. Failure to thrive
5. Chronic lung disease
6. Gastro-esophageal reflux

7. Tracheomalacia
8. Mild developmental disability (fine and gross motor) secondary to drug-exposure, prematurity and lung disease
9. Potential disruption of important attachment function with placement change
10. Many home health care and case management needs

II. Case Study of JS

JS is a five month old male born prematurely at 28 weeks gestation weighing 1-1/2 pounds whose mother was a 23 year old with 3 previous live births with little prenatal care and a history of cocaine abuse. His neonatal course was complicated by respiratory distress syndrome which required use of a ventilator and resulted in chronic lung disease (BPD). His lung disease gradually improved and he was weaned off of the ventilator but was maintained on oxygen therapy for months. He developed a hemorrhage in his brain that led to hydrocephalus which was treated initially with serial lumbar punctures (spinal taps) and then a drainage tube (ventricular peritoneal shunt) was placed. Additional problems included a heart murmur, a colostomy that was placed because of necrotic loss of part of his intestine, mild hearing loss, and eye disease.

During the four month hospital stay, his mother lost interest in him and by the second month stopped visiting. CPS investigation revealed persistent drug use, and inability for her to care for the baby and his medical problems. He was finally discharged home in the care of a foster mother at four months of age on several medications for his chronic lung disease including portable oxygen, a portable cardiorespiratory monitor, as well as a variety of other nursing requirements because of other complications. The initial emergency foster home to which he was discharged had four other foster children and over the subsequent month, it was noted that JS began to lose weight and began to develop a skin ulcer on one side of his head. A report was made to the Child Welfare Agency and JS was transferred to another emergency foster home where weight gain has improved as well as his general care and condition.

He is currently involved in a high risk infant follow-up program, a home visit program for infant development and is eligible for services from CCS, CHDP, Regional Center, PL99-457. His mother visits sporadically and has not been able to get into a drug rehabilitation program nor a job training program. At a 6 month hearing, the child welfare worker will recommend placement in a special foster home in another county, which will require development of all new health and support services. The regional center serving the new county of placement does not have a visiting infant development program. He will require ongoing routine care from pediatrician, pulmonary specialist, neurosurgeon, gastroenterologist, general surgeon, cardiologist, ophthalmologist, audiologist, child development specialist and more.

Summary of Problems

1. Premature, drug-exposed baby.
2. Chronic lung disease.
3. Intraventricular hemorrhage and hydrocephalus.
4. Ventricular peritoneal shunt.
5. Colostomy secondary to necrotizing enterocolitis.
6. Hearing loss.
7. Grade 2 retinopathy prematurity with subsequent visual problems.
8. Mild heart murmur.
9. Gastro-oesophageal reflux.
10. Developmental delay secondary to prematurity, intraventricular hemorrhage, drug-exposure.
11. Multiple complex medical, home health, and logistical problems.
12. Unlikely reunification and possibility of out of county placement.
13. Third placement change in 6 months.

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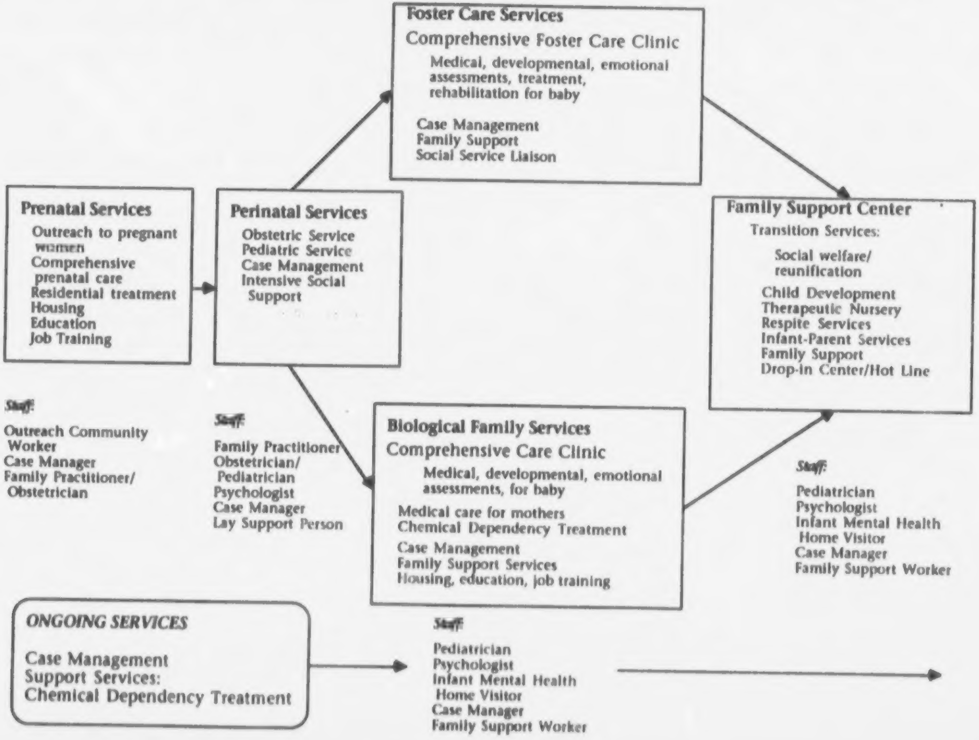
CONTINUUM OF SERVICE NEED FOR CHEMICALLY DEPENDENT WOMEN (CDW) AND CHILDREN

	CDW 15 - 44 YEARS OLD	PREGNANT CDW	BIRTH ISSUES	POST PARTUM CDW	INFANT/TODDLER	MOTHER-INFANT FOSTER MOTHER-INFANT
CASE MANAGER						
REHABILITATION						
TREATMENT						
DIAGNOSIS						
EARLY IDENTIFICATION						
PREVENTION						

CONTINUUM of CARE for CHEMICALLY DEPENDENT WOMEN & THEIR BABIES



Prenatal Services
- Outreach to pregnant women
- Comprehensive prenatal care
- Residential treatment
- Housing
- Education
- Job Training

Staff:
Outreach Community Worker
Case Manager
Family Practitioner/Obstetrician

Perinatal Services
- Obstetric Service
- Pediatric Service
- Case Management
- Intensive Social Support

Staff:
Family Practitioner
Obstetrician/Pediatrician
Psychologist
Case Manager
Lay Support Person

Foster Care Services

Comprehensive Foster Care Clinic
- Medical, developmental, emotional assessments, treatment, rehabilitation for baby
- Case Management
- Family Support
- Social Service Liaison

Biological Family Services

Comprehensive Care Clinic
- Medical, developmental, emotional assessments, for baby
- Medical care for mothers
- Chemical Dependency Treatment
- Case Management
- Family Support Services
- Housing, education, job training

Staff:
Pediatrician
Psychologist
Infant Mental Health Home Visitor
Case Manager
Family Support Worker

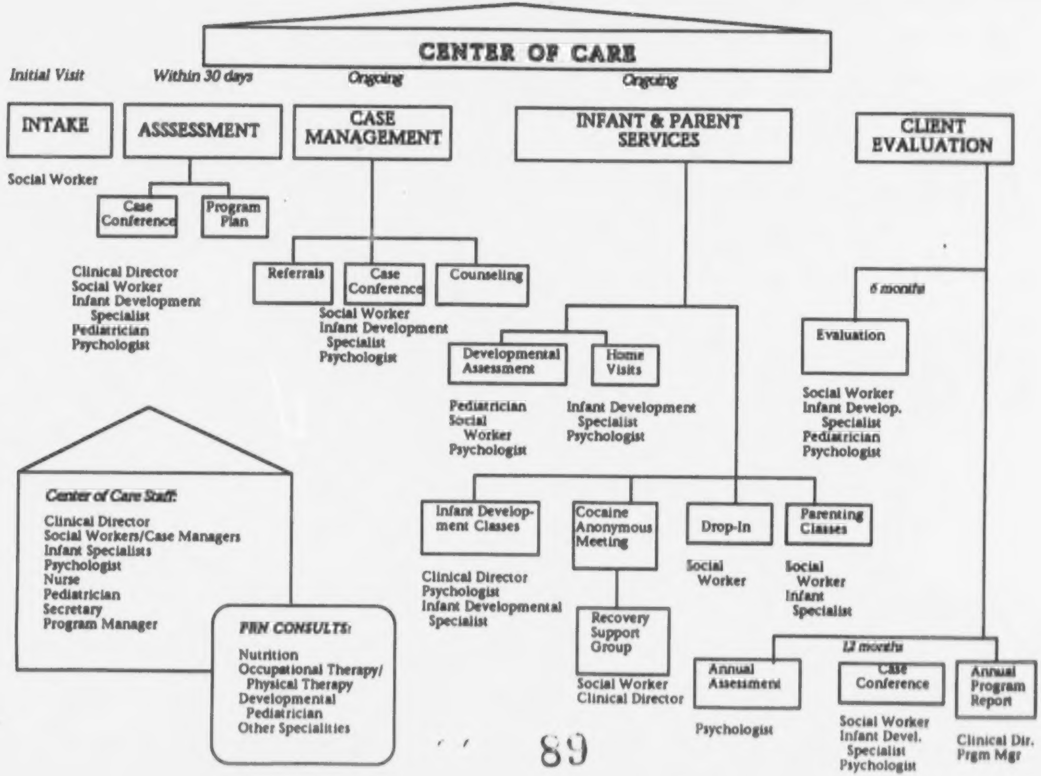
Family Support Center

Transition Services:
- Social welfare/reunification
- Child Development
- Therapeutic Nursery
- Respite Services
- Infant-Parent Services
- Family Support
- Drop-in Center/Hot Line

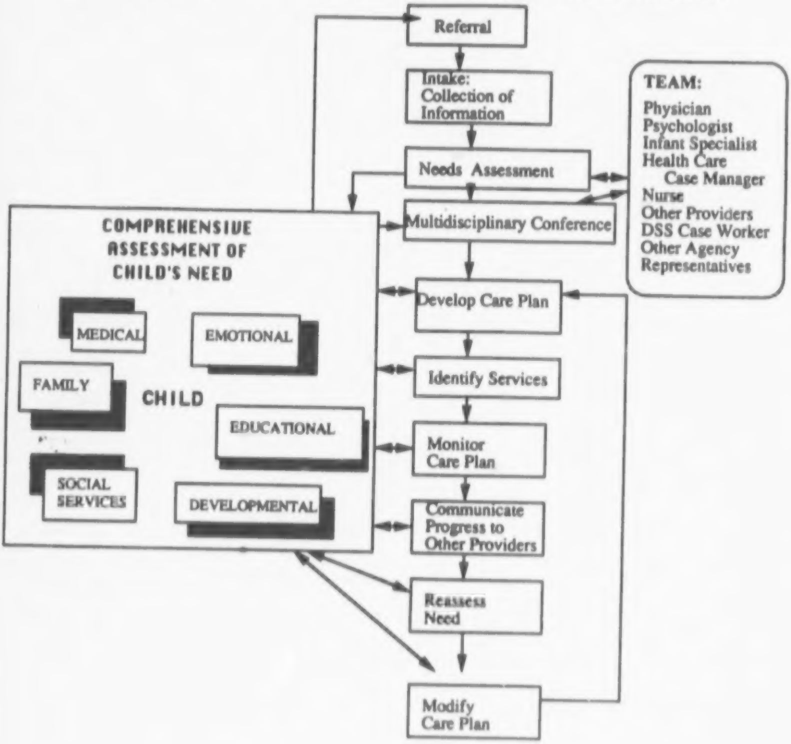
Staff:
Pediatrician
Psychologist
Infant Mental Health Home Visitor
Case Manager
Family Support Worker

ONGOING SERVICES

Case Management
Support Services:
Chemical Dependency Treatment


CENTER OF CARE
Initial Visit
Within 30 days
Ongoing
Ongoing
INTAKE
ASSSESSMENT
CASE MANAGEMENT
INFANT & PARENT SERVICES
CLIENT EVALUATION
Social Worker
Case Conference
Program Plan
Clinical Director
Social Worker
Infant Development Specialist
Pediatrician
Psychologist
Referrals
Case Conference
Counseling
Social Worker
Infant Development Specialist
Psychologist
Developmental Assessment
Home Visits
Pediatrician
Social Worker
Psychologist
Infant Development Specialist
Psychologist
6 months
Evaluation
Social Worker
Infant Develop. Specialist
Pediatrician
Psychologist
Center of Care Staff:
Clinical Director
Social Workers/Case Managers
Infant Specialists
Psychologist
Nurse
Pediatrician
Secretary
Program Manager
PRN CONSULTS:
Nutrition
Occupational Therapy/Physical Therapy
Developmental Pediatrician
Other Specialities
Infant Development Classes
Cocaine Anonymous Meeting
Drop-In
Parenting Classes
Clinical Director
Psychologist
Infant Developmental Specialist
Recovery Support Group
Social Worker
Clinical Director
Social Worker
Social Worker
Infant Specialist
12 months
Annual Assessment
Case Conference
Annual Program Report
Psychologist
Social Worker
Infant Devel. Specialist
Psychologist
Clinical Dir.
Prgm Mgr

HEALTH CARE CASE MANAGEMENT FOR VULNERABLE CHILDREN


Referral
Intake: Collection of Information
Needs Assessment
Multidisciplinary Conference
Develop Care Plan
Identify Services
Monitor Care Plan
Communicate Progress to Other Providers
Reassess Need
Modify Care Plan
TEAM:
Physician
Psychologist
Infant Specialist
Health Care Case Manager
Nurse
Other Providers
DSS Case Worker
Other Agency Representatives
COMPREHENSIVE ASSESSMENT OF CHILD'S NEED
MEDICAL
EMOTIONAL
FAMILY
CHILD
EDUCATIONAL
SOCIAL SERVICES
DEVELOPMENTAL

MATRIX I

	Individual Factors			Relational Factors	Environmental Factors
	PHYSICAL DEVELOPMENT	EMOTIONAL DEVELOPMENT	COGNITIVE DEVELOPMENT	FAMILY RELATIONSHIP FAMILY FUNCTION	SOCIAL RELATIONSHIPS - PEERS - INSTITUTIONS - SCHOOLS
REHABILITATION					
TREATMENT					
DIAGNOSIS					
EARLY IDENTIFICATION					
PREVENTION					

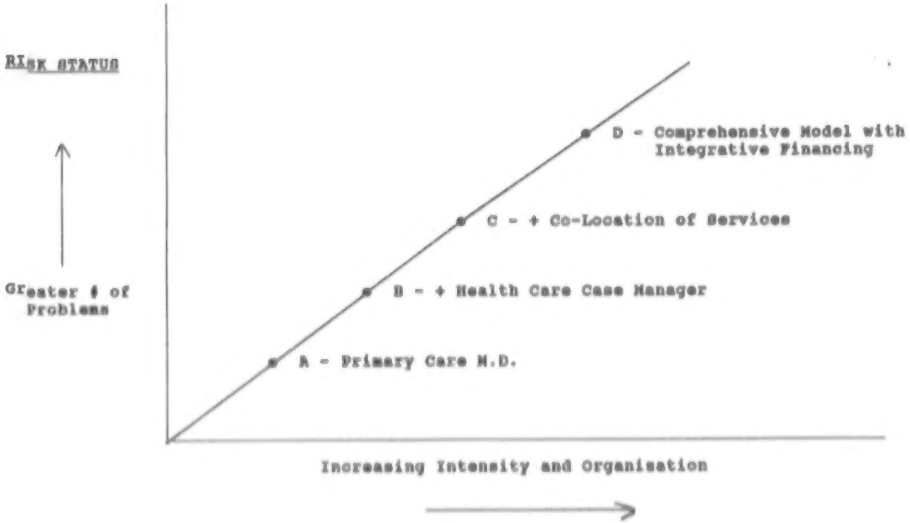
MATRIX II

	MEDICAL	PSYCHOLOGICAL	COGNITIVE-EDUCATION	FAMILY	SOCIAL
REHABILITATION	Title XIX Title V		PL 94-142		
TREATMENT	Title XIX Title V	Title XIX ADM Block Grant PL 94-142 PL 99-457	PL 94-142 PL 99-457	Title XX PL 99-457	
DIAGNOSIS	Title XIX Title V EPSDT	Title XIX ADM Block Grant PL 94-142 PL 99-457	Title XIX PL 94-142 PL 99-457	Title XX PL 99-457	
EARLY IDENTIFICATION	Title XIX Title V EPSDT MCH Block Grant Primary Care Block Grant	Title XIX ADM Block Grant PL 94-142 PL 99-457 EPSDT	Title XIX PL 94-142 PL 99-457 EPSDT	Title XX PL 99-457	
PREVENTION*	EPSDT WIC Title XIX MCH Block Grant Primary Care Block Grant	PL 99-457 Headstart Primary Care Block Grant	PL 99-457 Headstart	PL 99-457 Title XX Headstart AFDC Food Stamps SSI	AFDC Housing Food Stamps Other income support

Miscellaneous Federal Programs: Child Abuse Prevention and Treatment Act Programs; Developmental Disabilities Assistance and Bill of Rights Act Programs; Family Planning Programs; Adolescent Family Life Programs, Food Stamps, Champus, NIMH-Child and Adcolescent Service System Program (CASSP); Title IV-E, Title X

*Preventions Programs: Family Support Programs; Parent Training Programs; Teen Pregnancy Prevention Programs, Primary Mental Health Programs, Parent Infant Programs; Homebuilders Programs; -- Program of proven efficacy but without current funding.

DIAGNOSIS OF RISK/SERVICES


RISK STATUS
Greater # of Problems
D - Comprehensive Model with Integrative Financing
C - + Co-Location of Services
B - + Health Care Case Manager
A - Primary Care M.D.
Increasing Intensity and Organization

Chairman **Miller**. The committee has been joined by another member, Congressman Weiss, from New York. Ted, do you have any statement you'd like to make? And also we've been joined this morning by Congressman Rangel who sits as a member of the Ways and Means Committee but also is the Chairman of the Select Committee on Drugs and Narcotics. Congressman, do you have a statement you'd like to make?

Mr. **Rangel**. Mr. Chairman, I want to laud your leadership and that of this committee for concentrating on what I think is the most vital resource that our nation has if it's going to resist those that threaten our national, economic and national security generally.

For those who don't believe that we are prepared to spend the dollars to deal with the problem I ask them to really take a look at the budget and to see how much we are prepared to pay to keep our kids warehoused in jail; to really take a look at the billions of dollars that we prepared to invest in arrest and arraignment and in the court system generally; to see how much we're prepared to give, through Medicaid, to doctors who sometimes violate the law, as they dispense legal drugs to drug addicts in the poor communities, to see what is happening with the rehabilitation programs where these age a lot of medical professionals, but from which kids leave just as illiterate as they were when they entered them.

And, of course, the area that you have selected to look at this morning is one of the saddest indictments, I think, of a civilization. To see children being born addicted to drugs, screaming in pain and agony and abandoned in many cases by their teenaged addicted mothers, leaving that child in the hands of public officials and public hospitals, sometimes not even touched by the foster care whether it's good or whether it's bad. And to see the silence of our spiritual leaders as we see God's work being distorted in these types of births. I just wonder how a Congress and nation can set its priorities as to whether or not the Sandinistas stay in government, whether to overthrow Noriega or bail out the S&Ls and to see what is happening to America and our unwillingness really to deal with this.

I was hurt and shocked that a new Secretary of Health and Human Services, who had the opportunity to say anything and that would have been leadership since the silence of the last 8 years is still with us that in this area of substance abuse where we had the opportunity at least to enlighten one of those points of light in the area of treatment, suggests that we should give sterile needles to the addicts.

I do hope that by having those of you that are on the front line seeing and feeling the pain every day that even though there is a generation that we have ignored, that is paying the price for it in some prisons or on the streets, are vulnerable to getting their heads shot off, that perhaps through this concerted effort that we can join forces at least for these children; and bring those people who have concerns about life before birth to come forward and show equal concern about life after birth and maybe perhaps we can get the leadership in this Congress to recognize that there is no greater threat to our national security than the abuse of our minds and bodies and those mothers that carry children through no fault of their own who come in carrying this heavy and painful burden.

I think hearings such as this under your leadership in some way demonstrate graphically how the Congress has attempted in a very patchwork type of way to come up with any plan, any idea to alleviate the problem and we ask is that right and people say it's right and we pass it.

But we can authorize and we can appropriate money but we can't legislate leadership. We need a strategy, we need a plan, we need a policy so as the Congress attempts to fill it we can see what is working and what is not working. And, you pointing out the fact that you need a road map in order to figure out what we have done, indicates that we, too, need someone to oversee, to give us direction as to what is happening at the local and state level, and we hope to learn a lot today. Thank you, Mr. Chairman.

PREPARED STATEMENT OF CONGRESSMAN CHARLES B. RANGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK AND CHAIRMAN, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

GOOD MORNING. THE TOPIC OF TODAY'S HEARING OF THE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES, "BORN HOOKED: CONFRONTING THE IMPACT OF PERINATAL SUBSTANCE ABUSE", FOCUSES ON THE MOST HEART-RENDING DIMENSION OF THIS NATION'S DRUG CRISIS. THEREFORE, I WOULD LIKE TO THANK CHAIRMAN MILLER FOR AFFORDING ME THE OPPORTUNITY TO PARTICIPATE THIS MORNING.

AS CHAIRMAN OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, AS A STATE LEGISLATOR, AND AS A PROSECUTOR, I HAVE FOR ALMOST THREE DECADES WITNESSED THE DEVASTATION AND DESTRUCTION WREAKED BY DRUG ABUSE. NOTHING, HOWEVER, HAS MADE ME FEEL MORE HELPLESS THAN WATCHING THE TINY BODIES OF INFANTS SQUIRMING AND SHAKING BECAUSE OF THE EFFECTS OF DRUG ABUSE. NOTHING HAS MADE ME MORE ANGRY AND DETERMINED TO END THE STRANGLE HOLD OF DRUGS ON OUR SOCIETY.

OVER THE YEARS THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HAS CONDUCTED SEVERAL HEARINGS ON THE IMPACT OF PRENATAL DRUG ABUSE ON INFANTS. AS DESCRIBED IN A HEARING IN THE LATE 1970'S, THE PROBLEM OF PRENATAL SUBSTANCE ABUSE APPEARED TO BE PRIMARILY ONE OF HEROIN ABUSE. BY THE 1980'S, WITH THE GENERAL INCREASE IN THE ABUSE OF OTHER TYPES OF DRUGS AND THE ADVENT OF THE AIDS EPIDEMIC, THE

PROBLEM OF PRENATAL SUBSTANCE ABUSE BECAME MORE COMPLEX. IN JULY OF 1987, THE SELECT COMMITTEE ON NARCOTICS HELD A HEARING AT HARLEM HOSPITAL IN NEW YORK ON INTRAVENOUS DRUG ABUSE AND PEDIATRIC AIDS. IN OCTOBER OF 1987 THE COMMITTEE VISITED BROWARD COUNTY MEDICAL CENTER IN FLORIDA WHERE WE HELD A HEARING ON COCAINE ADDICTED INFANTS.

THE FINDINGS WERE DEVASTATING:

-- THE NUMBER OF CHILDREN BORN AFFECTED BY MATERNAL DRUG ABUSE WAS INCREASING;
-- THE RANGE OF EFFECTS WAS EXPANDING; AND
-- NOT ONLY WERE DRUG TREATMENT SERVICES INADEQUATE, BUT PREGNANT WOMEN WERE AT TIMES DENIED SERVICES EVEN WHEN THEY WERE AVAILABLE.

THE PRESENT LEVEL OF DRUG ABUSE IN OUR SOCIETY GIVES REASON FOR CONTINUED ALARM. AN ESTIMATED 30 MILLION AMERICANS HAVE USED COCAINE. FIVE TO SIX MILLION USE COCAINE REGULARLY. HEROIN ABUSE CONTINUES AT SIGNIFICANT LEVELS WITH APPROXIMATELY 600,000 HEROIN ADDICTS. REGULAR MARIJUANA USERS NUMBER 25 MILLION AND ANOTHER 15 MILLION AMERICANS MAY USE IT OCCASIONALLY.

THESE STATISTICS REFLECT AN INCREASE IN DRUG USE AMONG WOMEN. MOST OF THESE WOMEN ARE IN THEIR CHILD-BEARING YEARS. NEW YORK CITY ALONE, IN 1987, REPORTED 2,588 BIRTHS TO MOTHERS USING ILLICIT DRUGS.

AMONG THE FIVE TO SIX MILLION REGULAR COCAINE USERS, AN ESTIMATED TWO MILLION ARE WOMEN. MOREOVER, WOMEN IN THEIR CHILD-BEARING YEARS CONSTITUTE AN EVER GROWING PROPORTION OF COCAINE USERS. IT HAS BEEN ESTIMATED THAT 10 PERCENT OF PREGNANT WOMEN HAVE TRIED COCAINE AT LEAST ONCE DURING THEIR PREGNANCY.

APPROXIMATELY 31 PERCENT OF AMERICAN WOMEN IN THEIR LATE TEENS AND TWENTIES INDICATED IN A 1985 SURVEY THAT THEY HAD USED MARIJUANA WITHIN THE LAST YEAR. LSD, PCP, AND HEROIN ARE ALSO BEING USED BY YOUNG WOMEN. ALL OF THESE SUBSTANCES USED DURING PREGNANCY HAVE THE POTENTIAL TO SERIOUSLY AFFECT PRENATAL HEALTH AND DEVELOPMENT.

THIS INCREASE IN DRUG USE BY YOUNG WOMEN IS CLEARLY RESPONSIBLE FOR THE GROWING NUMBER OF INFANTS WE ARE SEEING BEING BORN SUFFERING FROM THE EFFECTS OF MATERNAL DRUG USE. THE RANGE OF EFFECTS IS FRIGHTENING.

MANY OF THESE CHILDREN ARE BORN SUFFERING FROM WITHDRAWAL OR WITHDRAWAL-LIKE SYMPTOMS. SOME EXPERIENCE HEART ATTACKS, STROKES, AND RESPIRATORY PROBLEMS. STILL OTHERS ARE BORN PREMATURELY, ARE SMALLER AND HAVE LOWER BIRTH WEIGHTS -- FACTORS THAT INFLUENCE THEIR DEVELOPMENT. THERE IS ALSO MOUNTING EVIDENCE THAT MANY OF THESE CHILDREN ARE MORE VULNERABLE TO SUDDEN INFANT DEATH SYNDROME (SIDS) OR CRIB DEATH. MOREOVER, PRELIMINARY REPORTS INDICATE THAT

MANY OF THESE CHILDREN WILL EXPERIENCE A VARIETY OF POTENTIAL LONG TERM PROBLEMS SUCH AS MENTAL RETARDATION, HYPERACTIVITY, AND LEARNING DISABILITIES. PERHAPS THE MOST TRAGIC OF ALL ARE THE CHILDREN BORN SUFFERING NOT ONLY FROM THE DIRECT EFFECTS OF DRUG ADDICTION, BUT ALSO FROM AIDS TRANSMITTED AS A RESULT OF PARENTAL DRUG ABUSE.

INFORMATION REGARDING THE EFFECTS OF SPECIFIC DRUGS ON FETAL DEVELOPMENT IS MEAGER, ALTHOUGH RESEARCH IN THIS AREA HAS INCREASED DRAMATICALLY IN THE PAST FEW YEARS. FROM A POLICY PERSPECTIVE, HOWEVER, WHETHER IT IS COCAINE, HEROIN, OR MARIJUANA; A COMBINATION OF DRUGS; OR A DRUG-RELATED LIFESTYLE THAT CAUSES A PARTICULAR PROBLEM OF THE NEWBORN, THE BOTTOM LINE IS THAT WE MUST STOP THE USE OF DRUGS PARTICULARLY AMONG WOMEN IN THEIR CHILD BEARING YEARS.

HOW DO WE DO THIS? IT WOULD BE EASY TO POINT A FINGER AT THE MOTHERS OF THESE CHILDREN, BUT THAT WILL NOT SOLVE OUR PROBLEM. THESE MOTHERS ARE NOT RESPONSIBLE FOR THE BUMPER CROPS OF COCA, OPIUM AND MARIJUANA IN DRUG PRODUCING COUNTRIES. THEY ARE NOT TO BLAME FOR THE INFLUX OF DRUGS INTO THIS COUNTRY, BECAUSE OUR BORDERS ARE, FOR ALL INTENTS AND PURPOSES, A SIEVE. AND, IT IS NOT THEIR FAULT THAT WE HAVE NOT HAD, UNTIL RECENTLY, FEDERAL FUNDS FOR DRUG EDUCATION OR PREVENTION PROGRAMS. IT IS NOT THE MOTHERS WHO HAVE PROMOTED SLOGANS RATHER THAN POLICIES AS THE PRIMARY WEAPON AGAINST DRUG ABUSE. FINALLY, IT IS NOT THE

MOTHERS WHO DETERMINE THE AVAILABILITY AND ACCESSIBILITY OF DRUG TREATMENT AND PRENATAL CARE.

TO PREVENT ANY MORE INFANTS FROM BECOMING VICTIMS OF COCAINE ABUSE, OUR FIRST LINE OF DEFENSE MUST BE A COMPREHENSIVE NATIONAL ANTI-DRUG STRATEGY. THE ANTI-DRUG ABUSE ACTS OF 1986 AND 1988 TOOK US A STEP TOWARD THAT OBJECTIVE. THEY PROVIDED NEW POLICIES AND ADDITIONAL ASSISTANCE IN THE AREAS OF INTERNATIONAL NARCOTICS CONTROL; INTERDICTION; DRUG LAW ENFORCEMENT; AND DRUG ABUSE TREATMENT, EDUCATION, AND PREVENTION.

ESPECIALLY CRITICAL TO THE SPECIFIC PROBLEM OF DRUG ABUSING WOMEN AND THEIR INFANTS IS THE NEED FOR ADDITIONAL DRUG TREATMENT RESOURCES. THE ANTI-DRUG ABUSE ACT OF 1986 AND 1988 EXPANDED RESOURCES FOR DRUG ABUSE TREATMENT SERVICES. FOR 1989, $806 MILLION WAS APPROPRIATED FOR THE FEDERAL ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH BLOCK GRANT. ANOTHER $75 MILLION WAS APPROPRIATED TO REDUCE TREATMENT WAITING LISTS.

THE NEED FOR TREATMENT SERVICES, HOWEVER, STILL FAR EXCEEDS THE AVAILABILITY OF SERVICES. THE NATIONAL INSTITUTE ON DRUG ABUSE ESTIMATES THAT THERE ARE 6.5 MILLION PEOPLE USING DRUGS IN A WAY THAT SERIOUSLY IMPAIRS THEIR HEALTH AND ABILITY TO FUNCTION. YET NATIONWIDE, AT ANY ONE TIME, THERE ARE ONLY 240,000 DRUG ABUSERS IN TREATMENT.

MOREOVER, THE SPECIFIC TREATMENT NEEDS OF PREGNANT WOMEN AND WOMEN IN THEIR CHILD-BEARING YEARS ARE NOT BEING ADEQUATELY ADDRESSED. THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS INDICATED IN ITS 1987 REPORT THAT STATES SPECIFICALLY IDENTIFIED DRUG TREATMENT SERVICES FOR WOMEN AND YOUTH AS AN AREA OF UNMET NEED. CLEARLY, NOT ONLY ARE ADDITIONAL TREATMENT RESOURCES NEEDED, BUT THEY MUST REACH THE VERY VULNERABLE POPULATION -- WOMEN IN THEIR CHILD-BEARING YEARS.

THE ANTI-DRUG ABUSE ACT OF 1988 BEGAN TO RESPOND TO THE NEEDS OF THESE WOMEN AND THEIR CHILDREN. THE ACT AUTHORIZED FEDERAL FUNDING OF MODEL DRUG AND ALCOHOL ABUSE PREVENTION, EDUCATION, AND TREATMENT PROJECTS FOR PREGNANT AND POST PARTUM WOMEN AND THEIR INFANTS. IT AUTHORIZED FUNDS FOR DEMONSTRATION PROGRAMS AND INDICATED THE NEED FOR RESEARCH IN THIS AREA. THE LEGISLATION ALSO REQUIRES A SET ASIDE OF AT LEAST 10 PERCENT OF A STATE'S ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT FUNDS FOR PROGRAMS AND SERVICES FOR WOMEN, ESPECIALLY PREGNANT WOMEN AND THEIR DEPENDENT CHILDREN, AND DEMONSTRATION PROJECTS TO PROVIDE RESIDENTIAL TREATMENT SERVICES TO PREGNANT WOMEN. THESE ARE CONCRETE INDICATORS THAT WE HAVE COME TO RECOGNIZE THAT DRUG ABUSING PREGNANT WOMEN AND THEIR INFANTS HAVE SPECIAL NEEDS. BUT, IT IS ONLY A BEGINNING.

MUCH MORE MUST BE DONE. THERE ARE A NUMBER OF EFFORTS THAT SHOULD BE UNDERTAKEN, WHICH SPECIFICALLY TARGET WOMEN IN THEIR CHILD-BEARING YEARS, PREGNANT WOMEN WHO ABUSE DRUGS, AND INFANTS OF DRUG ABUSING MOTHERS.

-- FIRST, FOR HIGH RISK WOMEN WHO ARE PREGNANT AND THOSE IN THEIR CHILD-BEARING YEARS THERE IS A NEED FOR:
  - EARLY IDENTIFICATION AND REFERRAL TO DRUG ABUSE TREATMENT;
  -- AVAILABLE AND ACCESSIBLE DRUG ABUSE TREATMENT;
  - AVAILABLE AND ACCESSIBLE PRENATAL CARE (MANY WOMEN STILL ONLY SEE AN EMERGENCY ROOM DOCTOR AT DELIVERY);
- DRUG ABUSE PREVENTION/EDUCATION OUTREACH PROGRAMS.

PERHAPS THE SERVICES PROVIDED BY DRUG TREATMENT CENTERS WILL HAVE TO BE EXPANDED TO INCLUDE PROVIDING PRIMARY HEALTH CARE SERVICES, AND SPECIFICALLY GYNECOLOGICAL AND OBSTETRICS SERVICES IF WE ARE TO REACH THE DRUG USERS WITH DESPERATELY NEEDED HEALTH CARE SERVICES.

-- SECOND, FOR THE MOTHERS AFTER THE BIRTH OF THE CHILD THERE IS A NEED FOR:
  - TRAINING TO MEET THE SPECIAL NEEDS OF THE CHILD, E.G., TRAINING TO USE SPECIALIZED EQUIPMENT;

- SOCIAL SUPPORT SERVICES TO REDUCE THE POSSIBILITY OF CHILD ABUSE OR NEGLECT;
- CONTINUED DRUG TREATMENT WITH FOLLOW-UP SUPPORTS.

-- THIRD, FOR THE CHILD THERE IS A NEED FOR:
  - BETTER HEALTH CARE BEFORE BIRTH;
  - ADEQUATE HEALTH CARE AFTER BIRTH;
  - SPECIAL SERVICES TO MEET LONG TERM NEEDS, E.G., LEARNING DISABILITIES AND BEHAVIORAL PROBLEMS
  - FOSTER CARE AND ADOPTION SERVICES.

-- FOURTH, WE MUST ALSO REACH OUT TO THE MEDICAL PROFESSION. IT IS THEY WHO MUST ENSURE THAT DOCTORS ARE AWARE OF THE SYMPTOMS OF DRUG USE; INFORM THEIR PATIENTS OF THE DANGERS OF DRUG ABUSE, ESPECIALLY PREGNANT WOMEN AND WOMEN IN THEIR CHILD-BEARING YEARS; AND RESPOND TO THE PATIENTS DRUG PROBLEM AS PART OF THEIR HEALTH CARE.

IN CLOSING, LET ME SAY, THERE IS MUCH TO BE DONE AND IT MUST BE DONE SOON, FOR WE ARE RISKING THE LOSS OF FUTURE GENERATIONS BY OUR INACTIVITY. WHILE I APPLAUD THE INITIATIVE AND CREATIVITY OF THE WITNESSES TODAY WHO WILL BE DESCRIBING PROGRAMS ALREADY UNDERWAY TO RESPOND TO THE NEEDS OF THE CHILDREN WHO HAVE BEEN AFFLICTED FROM BIRTH WITH THE CURSE OF DRUG ABUSE AND ADDICTION, I AM ALSO DEEPLY DISTRESSED THAT SUCH PROGRAMS ARE NEEDED. AS A

FATHER AND LEGISLATOR, I HAD HOPED THAT WE WOULD LEAVE A BETTER AMERICA TO THE NEXT GENERATION. I STILL HAVE THAT HOPE, BUT WE WILL HAVE TO DO MUCH TO REDEEM OUR SOCIETY FOR OUR CHILDREN.

THANK YOU, MR. CHAIRMAN, AND MEMBERS OF THE COMMITTEE FOR ALLOWING ME TO PARTICIPATE THIS MORNING. I COMMEND YOU FOR YOUR EFFORTS TO EXAMINE THE PROBLEM OF THE PERINATAL EFFECTS OF SUBSTANCE ABUSE. I HOPE THAT THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL AND THE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES WILL WORK TOGETHER OVER THE NEXT FEW MONTHS TO DEVELOP CREATIVE POLICIES AND INITIATIVES TO RESPOND TO THIS TRAGEDY.

Chairman MILLER. Thank you. Thank you again for all your work in this area on the Committee on Narcotics.

Mr. Parness.

STATEMENT OF JEFFREY PARNESS, J.D., PROFESSOR OF LAW, NORTHERN ILLINOIS UNIVERSITY, DE KALB, IL

Mr. PARNESS. Thank you. In the few minutes I have this morning I'd like to review with you what we can do to address this problem and particularly how the law might impact upon the problem.

Preventing life threatening and life impairing disabilities in newborns is certainly an interest which can be pursued by governments. That pursuit typically involves what most characterize as protection of potential human life. The U.S. Supreme Court recognized the legitimacy and importance of protecting potential human life. Protecting potential human life is distinct from protecting life, because the conduct which is addressed is usually conduct that precedes birth.

Potential human life in both federal, and particularly, state law is protected both in settings in which the born and the unborn are equated as well as in settings in which the born and the unborn do not receive comparable treatment.

The protection of potential human life can appear in a variety of ways. Laws can involve making money, food, and medical care available to pregnant women and others who choose to undertake conduct beneficial to the unborn or to avoid conduct that would be detrimental. Laws can help educate future parents and others with respect to prevention of birth disabilities. Finally laws can protect potential human life in more coercive ways.

In acting to protect potential human life, the traditional nonfinancial constraints on governmental power operate. Laws therefore must be neither arbitrary nor capricious; some legitimate goal has to be at stake. But unlike many other areas in which the government acts, there are further limits on the exercises of governmental power protective of potential human life. That is because in a good number of instances concerns are raised about possible infringement of constitutionally protected rights. I think you see the concern for constitutional rights in the decision in Roe versus Wade in which the Supreme Court clearly recognized the important and legitimate interest in protecting human life, but had to balance that with what it found to be a constitutional right with respect to decisions regarding pregnancy.

Other rights that are implicated in laws protecting potential life include constitutional protections regarding decisions on child begetting, child rearing and bodily autonomy.

Because governments are much freer to act when no constitutionally protected rights are implicated, and because pregnant (as well as fertile) women often can assert such rights with respect to laws protecting their future offspring, most laws protecting potential human life involve nonmaternal conduct. In these settings, typically the prospective mothers are in agreement with the government with respect to the laws affecting their future offspring. In a limited number of circumstances, however, laws might be operative with respect to maternal conduct against the wishes of the mother in circumstances in which the state seeks to protect her future offspring.

In the last few years there has been a significant growth in American laws protective of potential human life. For example, in the last few years there have been major developments in a number of states with respect to nonmaternal activities in the context of criminal laws. In 1986, the Minnesota legislature created a statutory scheme providing broad criminal law protection of the unborn. The scheme encompasses premeditated, intentional, grossly negligent, and even negligent conduct causing harm to the unborn and operates with respect to harm that causes termination of potential life as well as harm that surfaces in disabilities at birth. Later that year the Illinois General Assembly followed suit with a similar statutory scheme. Since then some other states have followed suit, including North Dakota and Washington.

Another major development with respect to protection of potential human life outside of conduct directed at prospective mothers involves the expansion of tort law so as to permit claims on behalf of those who allege their disabilities at birth were caused by the prebirth conduct of doctors or others. In many states claimants may include those who were in the pre-viability stage of fetal development at the time of the alleged misconduct. Since 1977, a number of states have even expanded further tort law so as to permit civil actions by claimants who were not even conceived at the time of the defending party's alleged misconduct.

There is often little controversy where laws address the conduct of prospective parents in order to protect potential human life. Consider, for example, laws providing for better prenatal care; laws providing for the treatment of drug or alcohol abuse on a voluntary basis; laws providing for warnings on labels of products known to cause disabilities at birth; and laws providing for financial support of medical treatment leading to childbirth. Such laws are relatively noncontroversial, I think, because they are noncoercive.

Most controversial of all laws protective of potential human life are those which address the behavior of potential parents, particularly pregnant women, and which operate regardless of the wishes of those whose behavior is at issue. As noted earlier, such laws often impact upon constitutionally protected rights and when they do, they can only be legitimated if they are found to serve a compelling state interest.

Laws involving substance abuse by pregnant women exemplify the controversy. Consider laws permitting substance abuse during pregnancy to serve as the basis for a criminal prosecution for abuse or neglect of the unborn child; for an order terminating parental rights respecting the later born child; or for an injunctive order restricting the activities of the pregnant women, including an order of confinement done in the context of a child custody proceeding.

Criminal child abuse prosecutions of women who took certain drugs or alcohol during pregnancy may now be permitted in at least some parts of the United States. California, for example, has a provision in the penal code which defines as a misdemeanor a parent's willful omission, without legal excuse, to furnish necessary medical attendance or other remedial care for his or her child, and thereafter deems a child conceived but not yet born to be covered.

The provision seemingly can be applied to infringe upon no constitutionally protected rights, and it clearly promotes the important and legitimate interest in protecting the potentiality of human life. The much publicized trial court dismissal in 1986 of child abuse charges against Pamela Rae Stewart in California casts some cloud on the future utility of that particular statute.

A simple hypothetical case serves to illustrate the possibilities of civil (rather than criminal) court involvement in terminating parental rights for prebirth conduct and for restricting the activities of pregnant women in order to protect potential human life. Consider a case involving a prospective mother whose conduct is found by a trial court to be causing significant harm to a developing fetus. May there ever be a sufficient cause in pre-birth conduct for the court to terminate at birth the woman's interest in the later born child? And, assuming a constitutionally protected interest is implicated, may there ever be a sufficiently compelling state interest, especially in conduct which is noncriminal in nature, to legitimate an injunction restricting the activities of a woman during a pregnancy so as to protect potential human life. Such an injuction would involve a guardian appointed on behalf of the developing fetus.

Courts are increasingly sympathetic to such orders. Just a few weeks ago the Florida Supreme Court ruled that a man who fails to support his unborn child's mother prior to birth loses his standing in a later adoption proceeding involving his later born child. Specifically, the court said "Because prenatal care of the pregnant mother and unborn child is critical to the well being of the child and of society, the biological father, wed or unwed, has a responsibility to provide support during the pre-birth period." Should not the same ruling hold true for the woman? Comparably, a number of different courts in the last few years have appointed guardians for fetuses whose prospective mothers were found to be involved in substance abuse during pregnancy; courts have also entered orders dictating that pregnant women cooperate with health officials in order to protect potential human life. Such orders have been issued by courts with diverse authority, including those with jurisdiction over family matters, juvenile matters, probate matters and criminal matters. Can such orders be entered even when maternal conduct is not criminal, though harmful to potential human life? For instance, consider instances of significant alcoholic consumption during pregnancy. In a case in 1983, a court was asked to assume custody over a pre-viable fetus and to order the pregnant woman to undergo a "purse string" operation so that the cervix would better hold the pregnancy. While declining to issue the order, the Supreme Judicial Court of Massachusetts said, "We do not decide whether, in some situations, there would be justification for ordering a wife to submit to medical treatment in order to assist carrying a child to term. Perhaps, the State's interest, in some cases, might be sufficiently compelling to justify a restriction of a person's constitutional right to privacy.'

The justification would certainly be found for laws mandating pregnant women to take a new wonder pill which prevents certain disabilities at birth and has no real significant adverse consequences on any woman who took the pill.

Notwithstanding the difficulties of constitutional interpretation, of line drawing and balancing, and of guiding and dictating social behavior through laws, coercive legal action protective of the unborn from the dangers posed by mom and others is on the rise. Apparently inadequate on their own are voluntary governmental programs involving prenatal care, educational advancement, drug treatment, and the like. The tragedies of premature infant deaths and preventable birth disabilities are hard to forget or to forget about. These tragedies will and should continue to be addressed by law.

Thank you.

Chairman MILLER. Thank you.

[Prepared statement of Jeffrey A. Parness follows:]

PREPARED STATEMENT OF JEFFREY A. PARNESS, PROFESSOR OF LAW, NORTHERN ILLINOIS UNIVERSITY COLLEGE OF LAW, DE KALB, IL

It is never easy to learn that a newborn has mental or physical disabilities which will inevitably result in either an early death or an impairment of the ability to live a whole and healthy life. It is particularly difficult to discover that such disabilities were fully, or substantially, preventable. Anger develops, fingers are pointed, fault is ascertained, prevention hereinafter is promised, action is taken. To seek to assure that more humans are born with a sound mind and body seems as American as apple pie. Governmental efforts in the enterprise do not appear inappropriate. What, if anything, may governments generally do to limit such disabilities? What non-financial constraints, if any, operate on governments choosing to undertake such a noble mission? And finally, as more is known about the causes of and cures for disabilities at birth, what in fact have governments been doing? This statement briefly addresses these questions.

I.

The prevention of life-threatening and life-impairing disabilities in newborns is certainly an interest which may be pursued by governments. Because such a pursuit typically involves the state in conduct preceding the birth of those to be protected, many have characterized such a pursuit as involving the protection of potential human life. The United States Supreme Court, in its decision in *Roe v. Wade*, expressly recognized and approved a state government's "important and legitimate interest in protecting the potentiality of human life." Seemingly, potential human life is protected through laws promoting live and healthy births, whereas human life is protected through laws promoting the continuing live and healthy condition of those who walk the earth today.

On occasion, lawmakers will seek to protect potential human life by equating the human unborn with those born, creating one class whose potential life is protected. For example, under some laws an already-born child and a developing fetus have been deemed victims of parental abuse and neglect. And, under some laws both a pregnant woman and her fetus have been deemed patients of certain doctors. On other occasions, lawmakers will protect potential human life though clearly rejecting any equation involving the born and the unborn. For example, certain states have both homicide and feticide laws within their criminal codes.

The protection of potential human life can be significantly promoted through most types of law (civil, criminal and regulatory) and by many types of lawmakers (legislatures, courts, and administrative agencies). Certain protections are most appropriate for state governments (criminal, tort and child custody laws), while others seem best undertaken at the national level (laws financing certain prenatal care). Laws protective of potential human life can serve the unborn exclusively, or can promote simultaneously other interests, such as maternal health. At times, the protection of potential human life is only an unintended consequence of a law chiefly serving some other purpose.

Laws can protect potential human life in a variety of ways. Laws can make money, food, medical care, and the like available to pregnant women, or to fertile men or women, who choose to undertake conduct directly beneficial to their unborn children, or who choose to avoid conduct which is likely to be harmful to their future offspring. And laws can help to educate future parents and others regarding the means by which they can assist in promoting live births and in preventing birth disabilities. Laws can also protect potential human life in more coercive ways. Tort claims or criminal prosecutions for acts already harmful to some unborn will deter similar conduct in the future. Beyond such general deterrence, coercive legal action may also seek to prevent foreseeable harm to some particular unborn by enjoining the conduct of those involved in, or having an impact upon, the relevant child-bearing process. Extreme cases may involve the imposition of certain conditions on a pregnant woman during a criminal sentencing hearing or a state's attempt to control a pregnant woman through a custody order involving her unborn child.

II.

In acting to protect potential human life, the traditional non-financial constraints on governmental power operate. Laws must be neither arbitrary nor capricious; some legitimate governmental goal must be at stake. Typically, this means laws protective of the unborn must be based on acceptable views of the causal connection between the conduct regulated and the chances for live and healthy birth. As well, the effectiveness of the law in promoting the desired conduct must be shown. Unlike many other police power analyses, however, there are often further limits on exercises of governmental power protective of potential human life. This is because such exercises often raise concerns about the infringement of constitutionally-protected rights. The decision in _Roe v. Wade_ is illustrative.

At issue in _Roe_ was a statutory scheme which effectively prohibited most pregnant women from procuring abortions. The prohibitions thus protected potential human life, serving a state interest which the Court found to be "important and legitimate." Yet, the scheme also restricted a woman's right to decide to terminate her pregnancy. Because a woman's right to choose was found within the constitutionally-protected right to privacy, and because the state's interest in all fetuses was not "compelling" (though legitimate), the scheme was invalidated. The Court did observe that the state had a compelling interest in protecting the potential life of all viable fetuses, so that third-trimester abortions generally could be outlawed.

While _Roe v. Wade_ concerned the constitutional right involving pregnancy termination, the Court's decision suggests a "compelling state interest" will be necessary to sustain any law protecting potential life which unduly infringes upon any other constitutionally-protected right. Other rights possibly implicated in potential life settings include decisional rights regarding childbegetting, childrearing, and bodily autonomy.

III.

Because governments are much freer to act where no constitutionally-protected rights are implicated, and because pregnant (as well as fertile) women often can assert such rights with respect to laws protecting their future offspring, most laws protecting potential life human involve non-maternal conduct. Where the conduct of prospective mothers is addressed, laws protective of potential life are usually welcomed by would-be mothers as these women typically join the state in seeking protection for their future offspring. In only certain limited circumstances will a state determine it is necessary to compel a woman's conduct against her wishes in order to benefit her future offspring. When such a compulsion constitutes a burden on any of the woman's constitutional rights, the rationale(s) prompting governmental action must, of course, be compelling.

In the last few years, there has been a significant growth in American laws protective of potential human life. An examination of some of these developments reveals the variations in the types of laws and lawmakers now concerned with promoting the birth of healthy infants.

A major development in the regulation of non-maternal activities protective of the unborn is the adoption of criminal laws characterizing the unborn as victims. Early in 1986, the Minnesota legislature created a distinct statutory scheme providing broad criminal law protection of the unborn. The scheme encompasses various forms of culpable activity causing injury to the unborn (premeditated, intentional, grossly negligent, and negligent acts) and varying forms of injury to the unborn (acts causing the termination of a fetus' potential life as well as acts causing injuries appearing at birth). Later that year the Illinois legislature enacted a similar statutory scheme, with the unborn deemed the possible victims of such crimes as intentional homicide, voluntary manslaughter, involuntary manslaughter, reckless homicide, battery, and aggravated battery. In 1987, the North Dakota legislature added several criminal offenses committed against unborn children, including murder, manslaughter, negligent homicide, aggravated assault and assault. Since then, the Washington state legislature has redefined the crime of assault in the second degree to include acts harming an unborn quick child. Of course, alterations of criminal laws may also influence significantly existing and related civil laws.

Another major development in the regulation of non-maternal activities protective of the unborn involves the expansion of tort law so as to permit claims on behalf of those who allege their disabilities at birth were caused by the pre-birth misconduct of doctors or others. In many states, claimants may include those who were in the previability stage of fetal development at the time of the alleged misconduct. Since 1977, a number of states have further expanded tort law so as to permit civil actions by claimants who were not even conceived at the time of the defending party's alleged misconduct.

There is often little controversy where laws address the conduct of prospective parents in order to protect the potential life of their future offspring. Consider, for example, laws providing for better prenatal care (nutritional food supplements to low-income pregnant women); for treatment of drug or alcohol abuse on a voluntary basis; for warnings on the labels of products known to cause disabilities at birth; and for financial support of medical treatment leading to childbirth. Such laws are relatively non-controversial because they are non-coercive.

Most controversial of all laws protective of potential human life are those which address the behavior of potential parents-especially pregnant women- and which operate regardless of the wishes of those whose behavior is at issue. As noted earlier, such laws often impact upon constitutionally-protected rights; when they do, they can only be sustained if there is demonstrated a compelling state interest. As well, it is often difficult to predict (or even describe) the consequences of such laws in advance of (or even after) their implementation. Thus, such laws may involve some speculation, and often necessitate re-examination a few years after implementation.

Laws involving substance abuse by pregnant women exemplify the controversy. Consider laws permitting substance abuse during pregnancy to serve as the basis for

1. a criminal prosecution for abuse or neglect of an unborn child;

2. an order terminating parental rights respecting the later-born child; and

3. an injunction restricting the activities of a pregnant woman, including an order of confinement.

Criminal child abuse prosecutions of women who took certain drugs or alcohol during pregnancy may now be permitted in at least some parts of the United States. In California, a provision of the penal code defines as a misdemeanor a parent's wilful omission, without legal excuse, to furnish necessary medical attendance or other remedial care for his or her child, and thereafter deems a child conceived but not yet born as an existing person within the provision. The provision seemingly can be applied to infringe upon no constitutionally-protected right, and it clearly promotes the "important and legitimate interest in protecting the potentiality of human life." The much-publicized trial court dismissal of child abuse charges against Pamela Rae Stewart in 1986 (while pregnant, she ignored a doctor's advice to stop taking drugs) casts a cloud on the statute's future utility.

A simple hypothetical case serves to illustrate the possibilities for civil court involvement in terminating parental rights for pre-birth conduct and in restricting the activities of pregnant women in order to protect potential human life. Consider a case involving a prospective mother whose conduct is found by a trial court to be causing significant harm to a developing fetus. May there ever be a sufficient cause in pre-birth conduct for the court to terminate at birth the woman's interest in the later-born child? And, assuming a constitutionally-protected interest is implicated, may there ever be a sufficiently compelling state interest (especially in conduct which is non-criminal) to legitimate an injunction restricting the activities of the woman during the pregnancy so as to protect potential human life (perhaps via a guardian appointed on behalf of the fetus)?

Courts are increasingly sympathetic to such orders. Just a few weeks ago the Florida Supreme Court ruled that a man who fails to support his unborn child's mother prior to birth loses his standing in (and thus his need to give his consent to) an adoption proceeding involving his later-born child. Specifically, the court stated: "Because prenatal care of the pregnant mother and unborn child is critical to the well-being of the child and of society, the biological father, wed or unwed, has a responsibility to provide support during the pre-birth period." Should not the same ruling hold true for the woman? Comparably, a number of different courts in the last few years have appointed guardians for fetuses whose prospective mothers were found to be involved in substance abuse during pregnancy; courts have also entered orders dictating that pregnant women cooperate with health officials in order to protect potential human life. Such orders have been issued by courts with diverse authority, including those with jurisdiction over family, juvenile, probate and criminal matters. Can such orders be entered even when maternal conduct is not criminal, though harmful to potential human life? For instance, consider instances of significant alcoholic consumption during pregnancy. In a case in 1983, a court was asked to assume custody over a pre-viable fetus and to order the pregnant woman to undergo a "purse string" operation so that the cervix would better hold the pregnancy. In declining to issue an order in the case before it, the Supreme Judicial Court of Massachusetts said: "We do not decide whether, in some situations, there would be justification for ordering a wife to submit to medical treatment in order to assist carrying a child to term. Perhaps, the State's interest, in some cases, might be sufficiently compelling. . . to justify such a restriction on a person's constitutional right of privacy."

As noted earlier, it is often difficult to predict the impact or to assess the consequences of laws mandating behavior by potential parents for the purpose of protecting their future offspring. Regarding state intervention in medical choices during pregnancy, one commentator recently noted:

> There are a number of practical difficulties in imposing an obligation to adhere to medically specified standards of conduct. First, insurmountable problems arise in trying to determine what types of conduct create an unacceptable risk for the fetus. Second, medical assessments of risk are sometimes wrong. Third, imposing legal obligations upon a woman to do or refrain from certain activities to protect her fetus will have a tremendously chilling effect. Some women may avoid seeking needed prenatal care. For others, the doctor will appear as an adversary, and the woman may not divulge important medical information out of the fear of sanctions or loss of control.
>
> Finally, there is great danger in overriding a competent individual's decision about treatment that affects her body. Society runs the risk of creating a new class--pregnant women--who

> are deemed incompetent to make decisions, while their peers, non-pregnant women and men, have the right to bodily integrity.

In judicial decisions as well, concerns have recently been expressed about the utility of decrees mandating certain conduct by potential parents. In a few different cases involving criminal court orders prohibiting conception or pregnancy as a term of probation, judges have expressed doubts not only on constitutional grounds, but on practical grounds. Judges have worried about the significant enforcement problems; the chilling effect on initiatives for prenatal care; the incentives for abortion; and the lack of resources for probation supervision.

Notwithstanding the difficulties of constitutional interpretation, of line-drawing and balancing, and of guiding and dictating social behavior through laws, coercive legal action protective of the unborn from the dangers posed by mom and others is on the rise. Apparently inadequate on their own are voluntary governmental programs involving prenatal care, educational advancement, drug treatment, and the like. The tragedies of premature infant deaths and preventable birth disabilities are hard to forget or to forget about. These tragedies will, and should continue to, be addressed by carefully-drawn laws whose consequences must be thoroughly studied after implementation.

Mr. Rangel. It's my honor to introduce to the panel Dr. Chavkin who is well known in the city and the country. She's an expert in child health and was Director of the Bureau of Maternity Services for the New York City Department of Health. Currently she is a Rockefeller Foundation Fellow at the Columbia University School of Public Health. Recently Dr. Chavkin completed a survey on the accessability of health care and rehabilitation services to pregnant women. It's a great honor that she shares her expertise with the Congress. I welcome you here with us today.

Dr. Chavkin. Thank you very much.

Chairman Miller. Welcome to the committee, again.

STATEMENT OF WENDY CHAVKIN, M.D., M.P.H., ROCKEFELLER FELLOW, SERGIEVSKY CENTER, COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH, NEW YORK, NY

Dr. Chavkin. Thank you very much and thank you for the opportunity to discuss with you today a very serious matter, the crack epidemic and particularly its devastating consequences for the well being of pregnant women and infants.

Although baseline data are sparse, as Dr. Halfon indicated, all the evidence suggests that there has indeed been a sizeable increase in the numbers of women using illicit drugs, primarily crack, during pregnancy.

In New York City, for example, the number of birth certificates indicating maternal substance use has tripled from a rate of 6.7 per thousand live births in 1981 to a rate of 20 per thousand live births in 1987. The number of certificates noting heroin use increased from about 200 in 1978 to 361 in 1986. Those noting cocaine which basically means crack increased from 68 in 1978 to 1,364 in 1986. Currently cocaine/crack is listed on two thirds of those birth certificates that note maternal substance use. One hospital based anonymous urine toxicology survey of newborns in 1985/86 indicated that 11 percent were positive for illicit drugs. Another such survey of women, these are New York City hospitals I'm talking about, another such survey of women in labor in 1988 yielded 13.5 percent positive for cocaine derivatives and another 1.5 percent to be positive for opiates. A similar survey in 1987 found 20 percent to be positive for cocaine. Data from New York City's municipal hospital system indicated drug related diagnoses in 5 percent of births in 1987.

There have been three major categories of societal response to this problem. The one that has attracted the most media attention, but is the rarest, has been the criminal prosecution of new mothers for their use of illicit drugs during pregnancy. As fetal personhood is not legally recognized, these have involved various legal approaches. In California, in the Reyes case of 1977 and the widely publicized Stewart case of 1986, attempts were made to prosecute these two women on grounds of criminal child abuse. Since the fetus is not recognized as a child, the statutes were deemed inapplicable and the cases dismissed. Subsequently the local prosecutor in northern California's Butte County has announced his intention of using a positive newborn toxicology screen in the baby as evidence of maternal illicit drug use, a prosecutable offense. Currently in

Florida, Toni Suzette Hudson is facing felony charges for transferring an illicit drug to a minor because of her prenatal crack use for which she faces a possible 30 year sentence, if convicted. In another twist, last year in Washington, D.C., Brenda Vaughn was convicted for forging a check to support her drug habit. As she was a first time offender, she would normally have been put on probation. However, when the judge learned she was pregnant, he decided to incarcerate her for the duration of her pregnancy, stating "I'll be darned if I'll have a baby born addicted."

The move towards criminal prosecution reflects, I believe, deep seated ambivalence about whether addiction constitutes willful criminal behavior or a medical illness, despite two Supreme Court decisions in 1925 in the Linder case and in 1962 in Robinson versus California, two Supreme Court decisions that drug addiction was an illness. The move also reflects a tendency, which I believe has its roots in the anti-abortion movement, to view pregnant women and fetus as separate with competing and even antagonistic interests. Whereas previously pregnant women with alcohol or drug addiction problems were considered to be in need of help, now some perceive them as willful wrongdoers toward the fetus.

The second major category of response has been invocation of the child neglect apparatus. Some states, New York is one, consider parental habitual drug use as prima facie evidence of child neglect.

It is widespread practice in New York City to screen neonatal urine for the presence of illicit drugs when maternal substance use is suspected. Criteria for suspicion vary and are rarely articulated in protocols. A positive toxicology screen is interpreted as evidence of maternal repeated illicit substance use and therefore prima facie evidence of neglect and triggers a mandatory report to our local child Protective Service Agency which keeps changing its name. I call it S.S.C. but it has a new one now.

Our local child protective service agency then conducts an investigation and if it deems the woman to be a neglectful parent the agency files charges in Family Court and places the child in foster care. Because of the increasing numbers of such cases and the shortage of foster homes these investigations are often prolonged and in the interim the babies born in hospitals or what we call in New York congregate care facilities. Group institutional care in New York City for six to twenty-four babies. In 1987 when the boarder baby crisis first peaked in New York City maternal substance use was the primary reason for boarder baby status accounting for 40 percent of the 300 plus cases that boarded in hospital on any given day. Approximately one third of those infants were ultimately discharged to their biological family after boarding in hospitals an average of 50 to 60 days. To clarify, boarding means that the child is medically ready for discharge. A recent report by the New York City Comptroller indicated that maternal drug use and inadequate housing were the two primary reasons for boarder status and that there were approximately 300 children under two years of age boarding in hospital and another 130 in congregate care on any given day.

The third category of societal response is to offer drug treatment and prenatal care for addicted women. Various federal agencies and the Surgeon General have extensively documented this nation's failure to provide prenatal care for all who need it. Unfortunately, the situation regarding drug treatment for pregnant women is even worse. I recently concluded a survey of 78 drug treatment programs in New York City. Fifty-four percent of them categorically refused to treat pregnant women. Sixty-seven percent of them refused to treat pregnant women on Medicaid and 87 percent of them had no services available for pregnant women on Medicaid addicted to crack. Less than half of those programs that did accept pregnant women provided or arranged for prenatal care. Only two programs made provisions for clients' children, yet lack of child care is a major obstacle to participation in drug treatment for many women as the National Institute for Drug Abuse documented a decade ago.

This paucity of treatment options for pregnant women reflects a legacy of discrimination against women addicts by drug treatment programs which was also reported by the National Institute for Drug Abuse a decade ago. It also reflects medical uncertainty over the optimal medical management of addiction during pregnancy. There is medical controversy over the optimal methadone dosage during pregnancy. Other treatment modalities for the treatment of crack addiction includes psychotherapy, acupuncture and other medications such as certain antidepressants and anticonvulsants. The efficacy of psychotherapeutic approaches and acupuncture requires assessment in formal clinical trials. Experimental drug studies, however, will not be performed on pregnant subjects. Promising results have been reported from the handful of programs around the country that bring together obstetric, drug treatment, pediatric and postpartum gynecologic care under one roof. Several of these programs emphasize parenting training and consider the therapeutic nursery model with parent education to be critical components. The Perinatal Addiction Center at Northwestern Hospital in Chicago, the Family Care Center at Jefferson Hospital in Philadelphia and the Program for Pregnant Addicts and Addicted Mothers at Metropolitan Hospital in New York City are three such successful examples. The Acupuncture Drug Treatment Program at Lincoln Hospital in New York City has recently added on site prenatal care and pregnancy-related health education and is developing on site child care and parenting classes. Others urge that residential drug treatment be available for mothers with young children. The Mabond Program Family Center, part of the Odyssey House Therapeutic Community on Wards Island in New York, provides residential treatment for 30 women with children under the age of five years. The women can pursue high school equivalency diplomas, job training and placement because of the on site provision of day care. Again, parenting education and early childhood stimulation are considered to be key components of the program.

The society has to make a choice as to whether to allocate resources to therapy or to sanctions. Even the criminal and the child neglect models presuppose the availability of therapy, as an addict cannot conform her behavior to the requirements of the law otherwise.

The consequences of pursuing the criminal prosecutorial approach may well be to deter women from seeking medical help at all, or from providing honest information to medical providers.

I urge us to devote resources to therapy and rehabilitation. This requires research directed at drug treatment modalities during pregnancy; the establishment of comprehensive drug treatment programs for new parents which offer the range of medical and social services needed by mother and infant; the incorporation of obstetric, gynecological and childcare services into drug treatment programs and very basically the expansion of the availability of drug treatment slots.

The crack and AIDS. epidemics make this problem an urgent one. If we do not rapidly create solutions, women, their babies and society face severe and long term consequences.

Thank you.

Chairman MILLER. Thank you.

[Prepared statement of Dr. Wendy Chavkin, follows:]

PREPARED STATEMENT OF WENDY CHAVKIN, M.D., M.P.H., ROCKEFELLER FELLOW, SERGIEVSKY CENTER, COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH, NEW YORK, NY

Thank you for the opportunity to discuss with you today a very serious matter - the crack epidemic and particularly its devastating consequences for the well being of pregnant women and infants.

Although baseline data are sparse, all the evidence suggests that there has indeed been a sizeable increase in the numbers of women using illicit drugs (primarily crack) during pregnancy.

In New York City, for example, the number of birth certificates indicating maternal substance use has tripled from 730 in 1981 (6.7/1000 livebirths) to 2586 (20.3/1000 livebirths) in 1987. The number of certificates noting heroin use increased from 206 in 1978 to 361 in 1986 and those noting cocaine (including crack) increased from 68 in 1978 to 1364 in 1986. Currently cocaine/crack is listed on 66% of those certificates noting maternal substance use. One hospital based anonymous urine toxicology survey of neonates 1985-86 indicated 11% were positive for illicit drugs. Another such survey of women in labor in 1988 yielded 13.1% positive for cocaine with an additional 1.4% positive for opiates (N=1300). A similar survey in 1987 (N=200) found 20% positive for cocaine. Data from the municipal hospital system indicated drug related diagnoses in 5% of births in 1987.

There have been three major categories of societal response to this problem. The one that has attracted the most media attention, but is the rarest, has been the criminal prosecution of new mothers for their use of illicit drugs during pregnancy. As fetal personhood is not legally recognized, these have involved various legal approaches. In California, in the Reyes case of 1977 and the widely publicized Stewart case of 1986, attempts were made to prosecute these two women on grounds of criminal child abuse. Since the fetus is not recognized as a child, the statutes were deemed inapplicable and the cases dismissed. Subsequently the local prosecutor in northern California's Butte County has announced his intention of using a positive newborn toxicology screen in the baby as evidence of maternal illicit drug use, a prosecutable offense. Currently in Florida, Toni Suzette Hudson is facing charges of "transferring on illicit drug from one person to another," because of her prenatal crack use for which she faces a possible 30-year sentence if convicted. In another twist, last year in Washington DC, Brenda Vaughn was convicted of forging a check to support her drug habit. As she was a first-time offender, she would normally have been put on probation. However, when the judge learned she was pregnant, he decided to incarcerate her for the duration of the pregnancy, stating he "would be darned if he'd have a baby born addicted."

The move toward criminal prosecution reflects, I believe, deep-seated ambivalence about whether addiction constitutes willful criminal behavior or a medical illness, despite two Supreme Court decisions (in 1925 in the Linder case and again in 1962 in Robinson v. California) that addiction was an illness. The move also reflects a tendency, which I believe has its roots in the anti-abortion movement, to view pregnant woman and fetus as separate with competing, even antagonistic interests. Whereas previously pregnant women with alcohol or drug addiction problems were considered in need of help, now some perceive them as willful wrongdoers toward the fetus.

The second major category of response has been invocation of the child neglect apparatus. Some states - New York is one - consider parental habitual drug use as prima facie evidence of child neglect.

It is widespread practice in New York City to screen neonatal urine for the presence of illicit drugs when maternal substance use is suspected. Criteria for suspicion vary and are rarely articulated in protocols. A positive toxicology screen is interpreted as evidence of maternal repeated illicit substance use, and therefore prima facie evidence of neglect, and triggers a mandatory report to Special Services for Children (SSC). SSC then conducts an investigation, and if it deems the women to be a neglectful parent, the agency files charges in Family Court, and places the child in foster care. Because of the increasing numbers of such cases and the shortage of foster homes, these investigations are often prolonged, and in the interim the babies board in hospitals or congregate care facilities (institutional care for 6-24 babies, run by the city). In 1987 at the first peak of the boarder baby crisis in New York City maternal substance use was the primary reason for boarder baby status, accounting for 40% of 300 plus cases. Approximately one-third of these drug-exposed infants were ultimately discharged to the biological family after boarding in hospitals an average of 50-60 days. A recent report by the New York City Comptroller indicated that maternal drug use (48%) and inadequate housing

(49%) were the two primary reasons for boarder status, and that there are approximately 300 children under 2 years of age boarding in hospital and another 130 in congregate care on any given day.

The third category of societal response is to offer drug treatment and prenatal care for addicted women. Various federal agencies and the Surgeon General have extensively documented this nation's failure to provide prenatal care for all who need it. Unfortunately the situation regarding drug treatment for pregnant women is even worse. I recently concluded a survey of 78 drug treatment programs in New York City (95% of the total). Fifty-four percent refused to treat pregnant women; 67% refused to treat pregnant women on Medicaid, and 87% had no services available to pregnant women on Medicaid addicted to crack. Less than half of those programs that did accept pregnant women (44%) provided or arranged for prenatal care; only two programs made provisions for clients' children. Yet lack of child care is a major obstacle to participation in drug treatment for many women, as the National Institute for Drug Abuse (NIDA) documented a decade ago.

This paucity of treatment options for pregnant women reflects a legacy of discrimination against women addicts by drug treatment programs, which was reported by the National Institute of Drug Abuse a decade ago. It also reflects medical uncertainty over the optimal medical management of addiction during pregnancy. There is medical controversy over the optimal methadone dosage during pregnancy. Other treatment modalities for the treatment of crack addiction include psychotherapy, acupuncture and other medications (certain antidepressants and anticonvulsants). The efficacy of psychotherapeutic approaches and acupuncture requires assessment in formal clinical trials. Experimental drug studies, however, will not be performed on pregnant subjects. Promising results have been reported from the handful of programs around the country that bring together obstetric, drug treatment, pediatric, post-partum gynecologic care under one roof. Several of theses programs emphasize parenting training and consider the therapeutic nursery model with parent education to be critical components. The Perinatal Addiction Center at Northwestern Hospital in Chicago, the Family Care Center at Jefferson Hospital in Philadelphia and the Program for Pregnant Addicts and Addicted Mothers at Metropolitan Hospital in New York City are three such successful examples. The Acupuncture Drug Treatment Program at Lincoln Hospital in New York City has recently added on-site prenatal care and pregnancy-related health education and is developing on-site child care and parenting classes. Others urge that residential drug treatment be available for mothers with young children. The Mabond Program Family Center, part of the Odyssey House Therapeutic Community on Wards Island in New York provides residential treatment for 30 women with children under the age of five years. The women can pursue high school equivalency diplomas, job training and placement because of the on-site provision of day care. Parenting education and early childhood stimulation are considered key components of the program.

The society has to make a choice as to whether to allocate resources to therapy or to sanction. Even the criminal and child neglect models presuppose the availability of therapy, as an addict cannot conform her behavior to the requirements of the law otherwise.

The consequences of pursuing the criminal prosecutorial approach may well be to deter women from seeking medical help at all, or from providing honest information to medical providers.

I urge us to devote resources to therapy and rehabilitation. This requires:

- research directed at drug treatment modalities during pregnancy
- the establishment of comprehensive drug treatment programs for new parents, which offer the range of medical and social services needed by mother and infant;
- the incorporation of obstetric-gynecologic and child care services into drug treatment programs;
- the expansion of drug treatment slots.

The crack and AIDS epidemics make this problem an urgent one. If we do not rapidly create solutions, women, their babies and society face severe and long-term consequences.

Thank you.

Chairman MILLER. Mr. Rice.

STATEMENT OF HAYNES RICE, HOSPITAL DIRECTOR, HOWARD UNIVERSITY HOSPITAL, WASHINGTON, DC

Dr. RICE. Good morning, ladies and gentlemen. My name is Haynes Rice. I have served for the past 10 years as the director of Howard University Hospital, here in Washington, D.C., a 500 bed teaching hospital of the Howard University Center for the Health Sciences. Before coming to Howard and Washington, D.C., I was Deputy Commissioner of Health for the City of New York and Acting Director for a year at Harlem Hospital.

Under the Deputy Commissionership I had the responsibility of "boarder" babies in 1970 where we had an average census of 200 children a year and we counted it a real success where we got the number from 200 to 147. So it is not a new problem.

I come before you speaking primarily to the issue of "boarder" babies. Before the end of last year Washington, D.C. did not have a problem with "boarder" babies. We define "boarder" babies as any child who is well, ready to go home and has not had parental contact within the last 30 days. While it might seem incredible to some to believe that the mother would walk away from a child, it's very real and an increasing phenomenon among urban drug-abusing females. The immediate impact of this is severe overcrowding of the neonatal intensive care units and pediatric units in hospitals and it is an ineffective use of resources. The longer term problem is an inability to discharge the child to an appropriate setting, causing the hospital to act as a caretaker for weeks and even months and even years.

As I said "boarder" babies are not a new phenomenon and in New York with the heroin epidemic in the early 70s had as high as 200 babies on a daily basis. Some of these children literally ended up going to school from the hospital due to the slowness of governmental response to provide timely foster care, homes or adoption alternatives.

I say we are now facing with this crack drug the same kind of problem. But there was some kind of support system for the earlier children in extended families here in Washington. Often grandparents would take over the responsibility for raising the child and providing a more stable environment or there would be adequate access to public operating facilities to care for the children. These historic alternatives helped keep the problem manageable in the past years so that not too many children ended up living in hospitals. This has changed and the hospitals are caught in the middle.

In the five month period between August of 1988 to December of 1988 the pediatric neonatologist at Howard University conducted a study of long stay infants and found some startling figures. The occupancy rate for the five months was 120 percent. The year to date occupancy was 114 percent. These figures came out because the normal expected stay for a newborn is three days. The average length of stay for this period was over 12 days. The longer length of stay is required for observation of drug withdrawal symptoms of babies born to drug-abusing mothers. And in our survey we found in terms of admitting drug abuse, from 18 to 32 percent during this six month period. That means that if we did testing you're probably talking about half of the deliveries.

Where this current problem differs from the historical problem is the reach of the drug abuse across multiple generations; we're seeing 28 to 35 year old grandmothers who are themselves substance abusers and cannot readily step in to provide the social contact as in the past. In the mothers themselves there is increasing use and abuse of drugs during their pregnancy and right up to the date of delivery in some cases. In fact we did have a maternal death in a mother who bragged she was so high on crack she would not need an anesthetic for delivery. Of course babies born to drug-abusing mothers are often premature, low birth weight and suffer from drug withdrawal symptoms at birth. As an indication of the low health status of the fragile newborns, at one time in our hospital, out of a total of 45 babies in the nursery, only three were healthy enough to be fed by mothers.

It is typical of the recidivism that we see among drug-abusing mothers that women who delivered one child will become pregnant again and deliver another child prematurely, low birth weight and having drug withdrawal symptoms. One of the most tragic cases that we have is that of a 15 year old drug abuser who has delivered and abandoned a baby in our hospital. We have learned that she is pregnant again. The mother is H.I.V. positive.

The impact of the current problem: in the five month study which I previously mentioned there were 27 babies who were long stay babies with an average length of stay of 42.3 days. Nineteen of the 27 babies had drug abusing mothers. The longest stay infant had been in the hospital for 245 days at a cost in excess of $250,000. The hospital receives $6,100 for care of this baby regardless of the length of stay or the type of services performed.

The overcrowding problem is not just confined to one or two hospitals locally. The worst we have seen is that at one period we were unable to identify a neonatal intensive care unit between Philadelphia and Richmond. The worst the overcrowding problem has gotten internally was when we had a high of 55 babies in a unit designed for one that was capable of taking care of 35 babies.

This does impact the larger society because if there is not a neonatal care bed within the care between Philadelphia and Richmond, then many of our patients are having to be shifted around and there aren't accommodations available for those normal deliveries who end up premature.

The impact of the problem goes far beyond poor women and their children that was discussed. Besides the expected increase in maternal mortality due to the poor health status of these delivering mothers, we are seeing access to services by nonpoor women, middle class women being threatened because of the larger number of poor women requiring more health care resources. We are also seeing an impact on malpractice costs and the resultant dampening effect on the practice of certain medical specialties like OB/GYN in the Washington, D.C. area.

A telephone survey of the local Washington, D.C. hospitals conducted last week indicated that there were 41 abandoned babies in Washington, D.C. area. At Howard University Hospital we had 21 and the rest being at Children's Hospital, D.C. General Hospital, George Washington University Medical Center and the Georgetown University Medical Center. One can readily see by these figures that this is not a problem confined to one type of hospital in terms of public general hospitals but it crosses the public/private sector.

In terms of what we see as recommendations to alleviate the problem, past efforts on the state level to address these problems have not been met with success. I think most of the programs that we've heard of today have been band aid approaches to the problem. If I can give you a 20 year history of New York, with a 200 capacity and now they're up to around 350. We can't say that we have anywhere in the country addressed the problem seriously enough at the state level for it not to become a national Congressional interest problem. We feel very strongly that the first issue of the drug czar ought to be these babies.

Number one again we ought to come up with some type of long-term care program where individual efforts such as Hale House in New York and Grandma's House in Washington—these can accommodate only 5 to 8 babies—are to be commended. These are limited approaches that cannot fully address the growing problem that our country and hospitals are facing unless there's a pointed effort by the federal government to facilitate.

Daily we see in the papers the violent side of the drug epidemic in our streets, but few of us see the tiny victims of the drug epidemic who did not chose to be a part of the problem.

We need to develop additional model programs that are responsive to the needs of these small babies, that can provide them with all the appropriate care and love, in a proper setting. Because the nature of the solution is longer term, most states have not moved aggressively to address the problem, but the need grows larger each day. A public/private partnership is needed to effectively meet this problem. We need to (1) streamline foster care and adoption provisions that are required in order to expedite the placement of these children. Currently, in Washington, D.C. it takes too long, often six months or more, to move through the foster care or adoption process, and during this time the child remains in an acute care setting even though the child no longer needs acute health care. This is an inappropriate use of resources and more important not a proper setting for a child.

A child in terms of the process we need, the mother has to sign twice and then have 10 days to change her mind. The mother is gone. She leaves the hospital often having given the wrong name. Within three days we can't find her. There aren't sufficient social workers to locate her and there is not a system because in our city we weren't even prepared for the problem because we never have experienced it before. We had small problems that the limited number of social workers could handle, but now it is such a large problem that I would think we're no different from many new cities facing crack with an inability of a social services agency—plus the fact that the private sector has gone out of the business for the care of the infant on a long-term care basis—that we now find our country really strapped without a system, without a program to deal with these children on a long-term care basis.

We need to provide for intermediate, temporary homes that are not connected with the correctional drug judicial system or the jail system. These small children need to be in a less expensive, non-acute setting where they can be nurtured with some type of bonding with people that can take place for healthy psychosocial development.

We need to increase the visibility on this aspect of the war on drugs so that we can make a positive mark on these lives. We have seen the federal government move to act against the enemy, those who would bring illegal drugs into our communities and profit from its distribution. We also must have efforts to assist the casualties of this war on drugs, and certainly these little babies are the great casualties in the drug war.

The conclusion is the administration and Congress and I want to commend the committee for addressing this, make further plans to combat the drug epidemic in our cities and administer justice to those who seek to victimize others in daily drug wars. Let us not forget to also show compassion toward these small babies who are victims who fall between the cracks. As a government some of you might think that we can't afford to do any more but as a society I think we cannot afford the consequences of doing anything less than doing something for these small babies.

Thank you for the opportunity to speak to you.

Chairman MILLER. Thank you very much and to all of the members of the panel for your help and your testimony.

[Prepared statement of Dr. Haynes Rice follows:]

Prepared Statement of Dr. Haynes Rice, Hospital Director, Howard University Hospital, Washington, DC

INTRODUCTION

GOOD MORNING LADIES AND GENTLEMEN, MY NAME IS HAYNES RICE; I HAVE SERVED FOR THE PAST 10 YEARS AS THE DIRECTOR OF HOWARD UNIVERSITY HOSPITAL, THE 500 BED TEACHING HOSPITAL OF THE HOWARD UNIVERSITY CENTER FOR THE HEALTH SCIENCES. BEFORE COMING TO HOWARD I WAS DEPUTY COMMISSIONER OF HEALTH WITH THE NEW YORK CITY HEALTH DEPARTMENT.

I COME BEFORE YOU TODAY TO SHARE MY INSTITUTION'S PERSPECTIVE ON A PROBLEM WHICH STRIKES AT THE VERY CORE OF OUR NATION'S PRESENT CONCERN WITH THE EFFECTS OF DRUGS AND DRUG ABUSE ON THE FABRIC OF THIS SOCIETY. THE PROBLEM THAT MY HOSPITAL AND HOSPITALS IN CITIES AROUND THE COUNTRY ARE FACING DAILY IS CARING FOR THOSE NEWBORN BABIES ABANDONED BY DRUG ABUSING MOTHERS. WE CALL THESE TINY, OFTEN UNSEEN, VICTIMS OF THE URBAN DRUG EPIDEMIC BOARDER BABIES.

BOARDER BABIES ARE DEFINED AS ANY CHILD IN OUR HOSPITAL WHO IS NO LONGER ACUTELY ILL, AND WHO HAS NOT HAD PARENTAL CONTACT WITHIN THE LAST THIRTY DAYS. WHILE IT MAY BE INCREDULOUS TO SOME OF YOU HERE TO THINK THAT A MOTHER WOULD JUST WALK AWAY FROM THE CHILD SHE HAS SO RECENTLY DELIVERED, IT IS A VERY REAL AND

INCREASING PHENOMENON AMONG URBAN DRUG ABUSING FEMALES. THE IMMEDIATE IMPACT OF THIS IS SEVERE OVERCROWDING OF THE NEONATAL INTENSIVE CARE UNIT AND PEDIATRIC UNITS. THE LONGER TERM PROBLEM IS AN INABILITY TO DISCHARGE THE CHILD TO AN APPROPRIATE SETTING, CAUSING THE HOSPITAL TO ACT AS A CARETAKER FOR WEEKS AND EVEN MONTHS AT A TIME.

HISTORY OF THE PROBLEM

BOARDER BABIES ARE NOT AN ENTIRELY NEW PHENOMENON FOR HOSPITALS. WHEN I WORKED IN NEW YORK CITY, THE PUBLIC HOSPITALS THERE HAD ABOUT 200 BABIES WHO HAD BEEN ABANDONED AT THE HOSPITALS BY HEROIN ADDICTED MOTHERS. SOME OF THESE CHILDREN LITERALLY ENDED UP GOING TO SCHOOL FROM THE HOSPITAL DUE TO THE SLOWNESS OF GOVERNMENTAL RESPONSE TO PROVIDE TIMELY FOSTER CARE, HOMES OR ADOPTION ALTERNATIVES.

BUT THERE WAS A KIND OF SUPPORT SYSTEM FOR THESE EARLY CHILDREN IN THE EXTENDED FAMILY OF THE PARENTS. OFTEN GRANDPARENTS WOULD TAKE OVER THE RESPONSIBILITY FOR RAISING THE CHILD AND PROVIDE A MORE STABLE ENVIRONMENT, OR THERE WOULD BE ADEQUATE ACCESS TO PUBLICLY OPERATED FACILITIES TO CARE FOR THE CHILDREN. THESE HISTORICAL ALTERNATIVES HELPED KEEP THE PROBLEM MANAGEABLE IN PAST YEARS, SO THAT NOT TOO MANY CHILDREN ENDED UP LIVING IN HOSPITALS. THIS HAS CHANGED NOW AND HOSPITALS ARE CAUGHT IN THE MIDDLE.

NATURE OF THE CURRENT PROBLEM

IN THE FIVE MONTH PERIOD OF AUGUST 1988 TO DECEMBER 1988 THE PEDIATRIC NEONATOLOGIST AT HOWARD CONDUCTED A STUDY OF THE LONG STAY INFANTS AND FOUND SOME STARTLING FIGURES. THE OCCUPANCY RATE FOR THE FIVE MONTHS WAS 120%. THE YEAR TO DATE OCCUPANCY WAS 114% THESE FIGURES CAME ABOUT BECAUSE WHEREAS THE NORMAL EXPECTED STAY FOR A NEWBORN IS THREE DAYS, THE ACTUAL AVERAGE LENGTH OF STAY WAS A LITTLE OVER TWELVE DAYS. THIS LONGER LENGTH OF STAY IS REQUIRED FOR OBSERVATION OF DRUG WITHDRAWAL SYMPTOMS OF BABIES BORN TO DRUG ABUSING MOTHERS.

WHERE THIS CURRENT PROBLEM DIFFERS FROM THE HISTORICAL PROBLEM IS THE REACH OF THE DRUG ABUSE ACROSS MULTIPLE GENERATIONS. NOW WE ARE SEEING 28 TO 35 YEAR OLD GRANDMOTHERS WHO ARE THEMSELVES SUBSTANCE ABUSERS AND WHO CAN NOT READILY STEP IN TO PROVIDE THE SOCIAL SUPPORT AS IN THE PAST. IN THE MOTHERS THEMSELVES THERE IS INCREASING USE AND ABUSE OF DRUGS DURING THEIR PREGNANCY AND RIGHT UP TO THE DELIVERY DATE IN SOME CASES. ON A MONTHLY BASIS 20-30% OF DELIVERING MOTHERS VOLUNTARILY ADMIT TO DRUG USE. THIS MEANS THAT ACTUAL USAGE IS PROBABLY CLOSER TO 40 - 50% OF ALL THE DELIVERING MOTHERS. OF COURSE THE BABIES BORN TO DRUG ABUSING MOTHERS ARE OFTEN PREMATURE, LOW BIRTH WEIGHT AND SUFFER FROM DRUG WITHDRAWAL SYMPTOMS AT BIRTH. AS AN INDICATION

OF THE LOW HEALTH STATUS OF THE FRAGILE NEWBORNS, AT ONE TIME ONLY 3 BABIES OUT OF A TOTAL OF 45 WERE HEALTHY ENOUGH TO BE FED BY THEIR MOTHERS AFTER BIRTH.

THERE IS A TYPE OF RECIDIVISM THAT WE SEE AMONG DRUG ABUSING MOTHERS IN THAT WOMEN WHO HAVE DELIVERED ONE CHILD WILL AGAIN BECOME PREGNANT AND DELIVER ANOTHER CHILD WITH THE SAME OUTCOME: PREMATURE, LOW BIRTH WEIGHT AND HAVING DRUG WITHDRAWAL SYMPTOMS. ONE OF THE MOST TRAGIC CASES THAT WE HAVE IS A 15 YEAR OLD DRUG ABUSER WHO HAS DELIVERED AND ABANDONED A BABY IN OUR HOSPITAL. WE HAVE LEARNED THAT SHE IS PREGNANT AGAIN: THE MOTHER IS HIV POSITIVE.

IMPACT OF THE CURRENT PROBLEM

IN THE FIVE MONTH STUDY WHICH I PREVIOUSLY MENTIONED THERE WERE 27 BABIES WHO WERE LONG-STAY BABIES WITH AN AVERAGE LENGTH OF STAY OF 42.3 DAYS. NINETEEN OF THE 27 BABIES HAD DRUG ABUSING MOTHERS. THE LONGEST STAY INFANT HAD BEEN IN THE HOSPITAL FOR 245 DAYS AT A COST IN EXCESS OF $250,000. THE HOSPITAL RECEIVES $6100. PER MEDICAID DISCHARGE FOR A PATIENT LIKE THIS REGARDLESS OF THE LENGTH OF STAY OR SERVICES PERFORMED.

THE OVERCROWDING PROBLEM IS NOT JUST CONFINED TO ONE OR TWO HOSPITALS LOCALLY: THE WORST WE HAVE SEEN IT GET WAS WHEN WE WERE UNABLE TO IDENTIFY AN EMPTY NICU BED BETWEEN PHILADELPHIA AND RICHMOND. THE WORST THE OVERCROWDING PROBLEM HAS GOTTEN

INTERNALLY WAS WHEN WE HAD A HIGH OF 55 BABIES IN A UNIT DESIGNED FOR A MAXIMUM OF 35 BABIES.

WITH THESE TYPES OF CONDITIONS, THE IMPACT OF THE PROBLEM GOES FAR BEYOND THE POOR WOMEN AND CHILDREN WHICH WE HAVE DISCUSSED. BESIDES THE EXPECTED INCREASE IN MATERNAL MORTALITY DUE TO THE POOR HEALTH STATUS OF THESE DELIVERING MOTHERS, WE ARE SEEING ACCESS TO SERVICES BY NON-POOR WOMEN, MIDDLE CLASS WOMEN BEING THREATENED BECAUSE OF THE LARGER NUMBERS OF POOR WOMEN REQUIRING MORE HEALTH CARE RESOURCES. WE ARE ALSO SEEING AN IMPACT ON MALPRACTICE COSTS AND THE RESULTANT DAMPENING EFFECT ON THE PRACTICE OF CERTAIN MEDICAL SPECIALTIES LIKE OB/GYN.

A TELEPHONE SURVEY OF THE LOCAL DC HOSPITALS CONDUCTED LAST WEEK INDICATED THAT THERE WERE, THEN, 41 ABANDONED BABIES IN WASHINGTON, DC WITH 21 AT HOWARD UNIVERSITY HOSPITAL AND THE REST DISTRIBUTED AMONG CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER, DC GENERAL HOSPITAL, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER AND GEORGETOWN UNIVERSITY HOSPITAL. ONE CAN READILY SEE BY THESE FIGURES THAT THIS PROBLEM IS NOT CONFINED ONLY TO ONE TYPE OF HOSPITAL (I.E., PUBLIC GENERAL HOSPITALS) IN THE HEALTH CARE SYSTEM.

RECOMMENDATIONS TO ADDRESS THE PROBLEM

PAST EFFORTS ON THE STATE LEVEL TO ADDRESS THESE PROBLEMS HAVE NOT MET WITH GOOD SUCCESS. WHILE INDIVIDUAL EFFORTS SUCH AS HALE HOUSE IN NEW YORK AND GRANDMA'S HOUSE HERE IN WASHINGTON ARE

TO BE COMMENDED, THEY ARE LIMITED APPROACHES THAT CAN NOT FULLY ADDRESS THE GROWING PROBLEM THAT HOSPITALS ARE NOW FACING UNLESS THERE IS A COORDINATED EFFORT THAT IS FACILITATED BY THE FEDERAL GOVERNMENT. DAILY WE ALL SEE IN THE PAPERS THE VIOLENT SIDE OF THE DRUG EPIDEMIC IN OUR STREETS, BUT FEW OF US SEE THE TINY VICTIMS OF THIS DRUG EPIDEMIC WHO DID NOT CHOSE TO BE A PART OF THE DRUG CULTURE BUT ARE HELD PRISONER BY IT.

WE NEED TO DEVELOP ADDITIONAL MODEL PROGRAMS THAT ARE RESPONSIVE TO THE NEEDS OF THESE SMALL BABIES AND THAT CAN PROVIDE THEM WITH THE APPROPRIATE CARE, AND LOVE, IN A PROPER SETTING. BECAUSE THE NATURE OF SOLUTIONS IS LONGER TERM, MOST STATES HAVE NOT MOVED AGGRESSIVELY TO ADDRESS THE PROBLEM, BUT THE NEEDS GROW LARGER EACH DAY THERE IS DELAY. A PUBLIC/PRIVATE PARTNERSHIP IS NEEDED TO EFFECTIVELY MEET THIS PROBLEM. THIS PARTNERSHIP WILL OF NECESSITY INVOLVE BOTH THE FEDERAL AND STATE GOVERNMENTS AND THE PRIVATE SECTOR.

I WOULD LIKE TO SUGGEST THE FOLLOWING ACTIVITIES THAT CAN BEGIN TO ADDRESS THE CURRENT BOARDER BABY PROBLEM:

- STREAMLINE THE FOSTER CARE AND ADOPTION PROVISIONS THAT ARE REQUIRED IN ORDER TO EXPEDITE THE PLACEMENT OF THESE CHILDREN -- CURRENTLY IN THE WASHINGTON AREA IT TAKES TOO LONG (OFTEN SIX MONTHS OR MORE) TO MOVE THROUGH THE FOSTER CARE OR ADOPTION PROCESS, AND DURING THIS TIME

THE CHILD REMAINS IN AN ACUTE CARE SETTING EVEN THOUGH THERE IS NO NEED FOR ACUTE HEALTH CARE.

- PROVIDE FOR INTERMEDIATE, TEMPORARY HOMES THAT ARE NOT CONNECTED WITH THE CORRECTIONS/JAIL SYSTEM -- THESE SMALL CHILDREN NEED TO BE IN A LESS EXPENSIVE, NON-ACUTE SETTING WHERE THEY CAN BE NURTURED AND WHERE SOME TYPE OF BONDING WITH PEOPLE CAN TAKE PLACE, FOR HEALTHY PSYCHO-SOCIAL DEVELOPMENT.

- INCREASE THE VISIBILITY ON THIS ASPECT OF THE WAR ON DRUGS SO THAT WE CAN MAKE A POSITIVE MARK ON THESE LIVES -- WE HAVE SEEN THE FEDERAL GOVERNMENT MOVED TO ACT AGAINST THE ENEMY: THOSE WHO WOULD BRING ILLEGAL DRUGS INTO OUR COMMUNITIES AND PROFIT FROM ITS DISTRIBUTION. WE ALSO MUST HAVE EFFORTS TO ASSIST THE CASUALTIES OF THIS WAR ON DRUGS, AND CERTAINLY THESE LITTLE BABIES ARE THE GREATEST CASUALTIES IN THIS DRUG WAR.

CONCLUSION

AS THIS ADMINISTRATION AND CONGRESS MAKE FURTHER PLANS TO COMBAT THE DRUG EPIDEMIC IN OUR CITIES AND ADMINISTER JUSTICE TO THOSE WHO SEEK TO VICTIMIZE OTHERS IN DAILY DRUG WARS, LET US NOT FORGET TO ALSO SHOW COMPASSION ON THESE SMALL BABIES WHO ARE THE

VICTIMS THAT FALL BETWEEN THE CRACKS. AS A GOVERNMENT, SOME OF YOU MIGHT SAY THAT WE CAN'T AFFORD TO DO ANY MORE, BUT AS A SOCIETY I THINK WE CAN NOT AFFORD THE CONSEQUENCES OF DOING ANY LESS THAN THESE RECOMMENDATIONS. THANK YOU FOR YOU ATTENTION.

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Chairman MILLER. Ms. Gallen, you mentioned something and I think Mr. Rice also mentioned an aspect of this problem that we found in the survey we did, supposedly something we're not supposed to find anymore in this country—and that is maternal death. Could you just elaborate on what you see happening in this regard?

Ms. GALLEN. Yes. I've got some statistics for the United States for 1986 which is the latest available which will let you know that just me telling you a story will not come across to this Committee in numbers until 1992 for you to really look at it.

But in 1986 the maternal mortality in this country was 7.2 per every 100,000 deliveries in the country. For the black population of course it was much higher, it was 18.8 per 100,000. For the white population 4.9.

We've had a death in the first four months this year so far. We've had a maternal mortality last year. This just didn't happen, we had a maternal mortality last year solely for drugs. We had another for, you might want to say "a lifestyle that was negative." Haynes Rice, they had one this year and I think they had one last year. So if you extrapolate this out and the District of Columbia does 10,000 deliveries a year the maternal mortality rate alone for this year would end up being something like 30 or 35 per 100,000 in the black population. I mean if you see this across the country so that we're doubling a figure and going totally backwards, a 20 year leap. If you look at our old figures this was the story in 1950, 1940.

We were doing very well, not doing as well with infant mortality but certainly maternal mortality. It's beginning to turn around and we're going back a great leap. Three mothers in this city alone out of 10,000 deliveries is just, it can't happen.

Chairman MILLER. Dr. Chavkin.

Dr. CHAVKIN. I just wanted to say that I think with maternal mortality, we're not doing very well in this country and we haven't all along. We're not going to meet the Surgeon General's 1990 goals by a long shot.

Chairman MILLER. I understand that but there was a notion that we were at least heading in one direction which was the better, maybe now plateaued to some extent. But now, the suggestion here is that by virtue of this problem we may very well be heading back in time in terms of the impact.

Dr. CHAVKIN. In New York where we have a rate of 39 maternal deaths per 100,000 live births every year and where the black rate is in the 80s we have just begun to see drug related maternal deaths. They are by no means an overwhelming preponderance of maternal deaths but they are appearing as a cause for the first time.

Chairman MILLER. Do we know in terms of the Bay Area in California?

Dr. HALFON. I know that in the Bay Area it's similarly high and one of the things that we have to remember is the reason we have maternal deaths have more to do with poverty and lack of prenatal care; that the current drug scourge we are witnessing is affecting and is integrally linked to the conditions of poverty and exacerbates this problem, and that we're adding insult to injury basically because we have not dealt with the problems of poverty in the first place.

Chairman **Miller**. You know I really find this to be clearly some of the most distressing testimony this committee has received in its six years of existence and I think it's most distressing because we see a problem that at best everybody has testified today we are under counting in terms of the magnitude. Everybody seems to be in relative agreement that it's going to continue to grow and, as Congressman Rangel knows, the difficulty we have in addressing supply and use, suggests that there's really no cap on the problem on drug-addicted babies or pregnant women. At the same time we see that it has the potential I think, as Dr. Halfon pointed out, simply to spill over into every other social service delivery system that we have in place. Some of that may be addressed by better coordination of those programs but I don't believe that anybody in the Congress is anticipating the kind of cost, Dr. Halfon, that you laid out for the state of California where you're now suggesting that these babies may be costing between half a billion and a billion, essentially new dollars just for this population. Is that correct?

Dr. **Halfon**. Well, and again these calculations that are provided were based on conservative estimates.

Chairman **Miller**. I understand that.

Dr. **Halfon**. The half billion to a billion dollars was based on 30 percent prematurity rate in the drug-exposed baby population in California.

Now let me qualify that. In the worst case prematurity rates in poor inner city populations are between 10 and 15 percent. What this represents is a doubling or tripling of that prematurity rate within the inner city population of the drug-exposed group so that it is somewhere between half billion and a billion additional dollars in California alone just for prenatal hospital costs.

Chairman **Miller**. I understand, you know, and what we're seeing, at least what the committee is starting to receive from areas around the country is on another dramatic increase and I guess it's measured in terms of Medicaid data with respect to newborns, infants and pregnant women that suggest again this dramatic escalation in costs. Now if my understanding is right from all the hospitals that have visited me because of all the activities in the Ways and Means Committee, somebody is paying for this. We may not be appropriating the money but private hospitals and public hospitals--and the distinctions are starting to be blurred here—it's coming out of somebody's pocket for the care of these children. We sometimes use the word epidemic a little bit loosely in the halls of Congress but when you start to see all of the various populations that these children will be affecting and touching in the next few years and the preliminary evidence from Los Angeles in terms of the impact now on the school system, because they've been tracking these children maybe longer than most other areas, it's frightening in terms of just what their impact may very well be on school districts as these children grow older.

Mr. Parness, I'm not sure yet, are you advocating, I'm not clear from your testimony, are you just laying out for us the notion that sanctions, various sanctions may be viable in this effort to stem the flow of drug-addicted women and babies?

Mr. **Parness**. I was asked to do an overview which I did provide. I am sympathetic to more coercive measures. I do think, though, that the chief responsibility for those measures lies with the state rather than the federal governments. One activity the federal government could do to prompt states in a more protective way I think would be——

Chairman **Miller**. I guess and you know and a lot of this is in terms of the combined information recognizing the absolute commitment that people have got to take some personal responsibility. I just fail to see how sanctions and especially criminal sanctions do anything but complicate this problem. I just don't see given this population—and I think there is some ambivalence about whether we're dealing with illness or criminal activity, what have you—how we change the outcome in terms of the kind of problem confronting us.

Mr. **Parness**. Might I address that?

Chairman **Miller**. Sure.

Mr. **Parness**. It seems to me that the criminal laws that we spoke of serve a number of different purposes. I think the least of which is to punish or otherwise act against those people who already undertook socially undesirable conduct. I think more importantly the existence of the criminal laws serves to educate, serves to deter future conduct, and serves as a statement of existing social policy that has spillover effects in terms of the civil laws so that the civil courts and the child custody determinations, civil courts in terms of parental termination, determinations, look to the criminal law as reflective of societal views and when it finds public policy supportive of protection of potential human life I think the civil courts are a little more willing to act.

I think people are more generally educated about their responsibilities. Part of the difficulty in the absence of criminal laws is the kind of misunderstanding we saw just a few moments ago with the statement made that fetal person is not recognized. That's just not true. Fetal person who is not recognized for purposes of the 14th amendment, for purposes of providing constitutional protection but the fetus and even the preconceived unborn are recognized in a variety of laws as having legal rights and people are recognized across the board whether it's tort law or property law or criminal law as having responsibilities not to harm potential human life.

And I think part of the——

Chairman **Miller**. I appreciate that argument and recognize the nature of that argument but if my goal is the reduction in the number of drug-addicted babies and the number of drug-addicted women and all of the results that come from that I am still at a loss. If I buy your argument, I'm at a loss. Should society choose sanctions as the notion as opposed to treatment? I don't see where sanctions end up providing for the goal which is the reduction in the incidents of this behavior. I'm looking for the successful model that leads me to that conclusion.

Mr. **Parness**. First of all it seems to me that I did not speak against treatment.

Chairman **Miller**. No, no, no. I understand that.

Mr. **Parness**. Secondly, I think in terms of the value and protection of potential human life we're not just talking about drug addiction which arguably is an illness, but we're talking about other kinds of conduct that can be detrimental to potential human life including conduct which generally is not viewed to be illegal, for example, the consumption of alcoholic beverages. It seems to me that when one takes a look at the societal interest in protecting potential human life we have to think about protecting potential human life not simply from conduct that involves drug abuse, alcohol abuse, but from a variety of other forms of conduct. That's why I included within my remarks conduct that not only is directed toward trying to guide in some ways the activities of prospective parents, but conduct involving the activities of those who have an impact on potential human life but who may not themselves be prospective parents. I think you see that in preconception torts, I think you see that in some of the criminal laws that are being passed by state legislatures that protect pregnant women and their developing fetuses from assaults by uninvited strangers. I think laws involving pregnant women are just one aspect of a more general concern that seems to be developing within state laws to protect potential human life both in the civil and criminal context.

Chairman **Miller**. Yes.

Dr. **Halfon**. Could I make a comment about that? I think that we have to strike some kind of judicious balance between certain kinds of sanctions but realizing the fact that a lot of the women we're talking about are women that this society has failed already. These are women, young girls, who are oftentimes, teenagers who become pregnant, who have been the victims of physical, sexual and emotional abuse. They are women who are using drugs because they're living in almost intolerable situations in which there's no way out and drugs become a very attractive coping mechanism, although an unsuccessful coping mechanism.

If we impose more and more sanctions we're going to get fewer and fewer of these women in the prenatal care. We're going to get fewer and fewer of them that will come in for drug treatment. It will serve more as a disincentive. What it does is shift the ball toward making this a sterile legal problem rather than realizing that this is illness, a very debilitating illness that has recidivism. You may get off drugs for a while, you might go back. But you can make steady constant progress. This is a complex illness that also has associated cultural, psychological, and social factors and that must also be addressed in a comprehensive way. By just passing more sanctions I think we're going to do more harm than good.

Chairman **Miller**. Let me say that I will try to recognize members in the order in which they appeared in committee this morning and we'll start with Dr. Rowland.

Mr. **Hastert**. You're not going to go back and forth?

Chairman **Miller**. We'll see, but I'm not going to let people who come in the last five minutes go before people who have been sitting here for 40 minutes. I've done it this way for six years and most members think it's the fairest way and I'm going to take people in order and I try to also provide time for the minority members of the committee.

Mr. **Rowland**. Thank you, Mr. Chairman.

Chairman **Miller**. Or we can do it strictly and we'll just recognize the absolute order in which they appear which most members again have endorsed in the committee. So however you want to do it.

Mr. **Hastert**. You have the gavel.

Mr. **Rowland**. Thank you, Mr. Chairman. As many questions as I'd like to ask our time is limited so let me make a comment first about Dr. Halfon referred to, so many agencies that women have to go to now. One of the proposals that has been made by the National Commission to Prevent Infant Mortality in fact has been introduced as legislation is to bring all of these agencies together so that the pregnant women can go to one place and get all the information she needs and does not have to have this engineering degree in order to find out what agencies do provide care. I just want to make that comment.

Insofar as saying whether or not drug addiction is a medical illness or not becomes extremely difficult. I don't think that we ought to say drug, I think we ought to specify what we're talking about because there's a pharmacophysiological difference between, as most everyone knows, alcohol, I believe there is some genetic problem that makes it an illness. I think people drink alcohol because of a problem with their genetics and it is a familial tendency to do that.

But I'm not sure that's true with drugs particularly of the alkaloid and cocaine which is a different kind of drug altogether from the other drugs we talk about because this is a central nervous system stimulant and others is a central nervous system depressant so I think when we talk about it we ought to talk about the difference in these drugs.

And I want to bring up something that Congressman Rangel mentioned a few minutes ago and he has very strong feelings about the needle exchange program. I'm still trying to resolve this in my mind about how to deal with this when one realizes that alkaloid cocaine gets into the blood stream almost as quickly being smoked as it does with I.V. needles and my particular interest in this is the spread of AIDS because of the exchange of needles. I'm just wondering why do addicts use needles anyway when the alkaloid gets into the blood stream just as quickly being smoked and I'd like to have your thoughts on what do you think about the needle exchange program? I'm not trying to raise a controversial point but I am just trying to get some idea. I'm trying to resolve this in my own mind about how to really deal with this.

Dr. **Halfon**. My understanding is that people who smoke crack cocaine initially get a very powerful hit; a euphoric effect that lasts for some period of time. However subsequent smoking of crack cocaine never gives you quite the same jolt that you got the first time and so what the people sometimes resort to is shooting cocaine and the actual injection of cocaine will give you that same kind of rush.

Clearly, there's a barrier in people's minds between smoking which is easy to do versus injecting yourself. For people who start off smoking crack cocaine there is a tendency to evolve into shooting it in some cases.

Again, we don't know what the percentages are. Probably the most startling or most concerning thing that has to do with that is the fact that in a survey that was recently done, and I don't have the exact figures at San Francisco General Hospital that was reported in the Journal of the American Medical Association earlier this year, found, that the H.I.V. positivity rate was higher in those who were injecting crack cocaine than in the heroin users.

That was very disturbing evidence, since crack cocaine which is a smokable drug is also being injected and causing higher H.I.V. in San Francisco rates than the heroin users.

In terms of a needle exchange program, I guess I don't, have much to offer, it's not something that I have much expertise on. My personal opinion is that anything we can do from a public health standpoint to stem the spread of H.I.V., I think that we should do. The needle exchange program bears further study. It should be tried to see if it does have some effect, because the impact of H.I.V. infection is extraordinarily devastating, and we're taking care of lots of kids right now that have H.I.V. infections because they got it from their mothers.

Mr. **Rowland**. Anybody else have a comment?

Dr. **Chavkin**. Well again, I think that one really can only talk about needle exchange in the context of significant accessibility of drug treatment. And that's the only way in which it would make any sense to me. If it was a very temporary measure because in that way you were going to enroll people on a mass level in treatment, but simply to give sterile needles when again I only know New York City numbers very intimately we have more than 30,000 people waiting for drug treatment slots.

Ms. **Gallen**. I think in the Washington, D.C. area the most popular route is smoking it, but we will see and are seeing an increase in H.I.V. positivity because of the amount of promiscuity that we're getting with the usage. That's where we're getting this. The young women that are using, because of crack, you only get 20 minutes or whatever high out of it. They will go on all night long, you hear them tell the story, really, it's impossible to imagine. So they need money, they need money quickly and they don't care. They don't pay attention to themselves. The need is so great to get that high back again that they will tell you they'll have 6, 8, 10 partners, it's nothing, they're driven. They're literally driven.

One of the other things that I wanted to say and we're talking about the legality, what we see if I think if we could open our doors for treatment we would have no problem at all. We have women coming to us daily saying take me in. Please save me from myself. And we have nothing we can offer them. And so it's not a matter of prosecution. If you could just find a place, they're willing to come there frightened out of their mind about what happened to them as they're coming down off this high. They have no more money or whatever and they become very frightened. And they will come in. We have, daily, women coming and wanting help.

Mr. **Rowland**. When we talk about drug abuse we often specify the drug that we're talking about because the action is so different. Rather than just putting drug abuse, thank you, Mr. Chairman.

Chairman **Miller**. Mr. Weiss?

Mr. **Weiss**. Thank you very much, Mr. Chairman. I'll also pick up with Dr. Rowland's concerns. As you know I chair the subcommittee on Human Resources of Government Operations and back in late February we held a hearing on so called pediatric AIDS and it is quite clear that at this point half the babies born with AIDS, born with H.I.V. are as a result of their mothers were either drug addicts or sexual partner with another drug addict.

Now it seems to me that taking every other aspect of drug use and the spread of AIDS out, just in that aspect of it I understand how especially when you count people whether it be in the hundreds or in the tens of thousands who are seeking to go into treatment, but for whom the treatment facility and the treatment slot is not there, how you can also tell them that we're not going to allow you to use a needle during that interim period while you're waiting to get into treatment because there's something morally wrong about that aspect of it, but you can go ahead and kill yourself or impregnate your sexual partner and then have a baby born with AIDS. It seems to me if we're passing moral judgment, that's a greater moral concern to me.

And the problem, this is where the problem is currently. The area of AIDS spread at this point is within drug use community, the I.V. drug use community across the country. We held hearings in Detroit on Monday of this week, 75 percent or more of the cases that are being diagnosed are within the drug use community, in the minority communities at that, and so it seems to me that we really do have to look at this. We say there is nothing wrong with allowing teaching people to bleach, use bleach to clean their needles. In Michigan you can buy needles in the drug stores, there's no law against it but there's something wrong and I can't make the connection but there's something wrong with giving a new or a fresh needle in exchange for the old one for someone who is trying to get into treatment in the New York program.

It just doesn't make any sense to me and again I don't want to create controversy. It seems to me we really ought to be able to look at this from a public health perspective rather than from a, I heard one law enforcement person describe this thing as well giving a drug addict a needle is the same as giving a voyeur binoculars. It seems to me that we ought to be looking at this in the perspective not of law enforcement but public health and if that's the perspective then it seems to me we can find ways of stopping people from killing themselves and infecting their partners and the babies that are born.

Thank you, Mr. Chairman.

Chairman MILLER. Mr. Hastert?

Mr. HASTERT. Thank you, Mr. Chairman, I'd like to ask Mr. Parness who gave testimony here this morning and states that society has to make a choice between therapy or sanctions. Not an and/or statement, but just an or. It seems to me in your testimony that maybe this is a lever; that maybe sanctions could be a lever that says this is wrong. I mean, we do it on airplanes, we say smoking is wrong. We shouldn't smoke. We use seat belts, we take all types of efforts to clean up our environment because we say it's wrong. We put in all types of sanctions and laws to educate people.

From your point of view doesn't this educate?

Mr. PARNESS. I think it does. If I was convinced that the money would be forthcoming tomorrow for all these treatment programs and to set up educational programs, then I would be less concerned about the lack of criminal laws and civil laws protective of the unborn. But I just don't see that happening in the near future and therefore I think it important that there are laws that make people more accountable for their conduct. With all due respect I understand that there are certain people who can't be held accountable, but there are others who can. I think it is not inappropriate for the government to try to force in some ways better conduct.

Mr. HASTERT. Let Wendy respond to that.

Dr. CHAVKIN. We're both just going to be asserting our beliefs about this point since I don't think either of us can document, I have not seen evidence that suggests to me that this does indeed successfully deter anybody. What I can tell you anecdotally, and I'm not able to present it in a sort of formal presentation of data, is that many women have reported staying away from the doctor, staying away from prenatal care and lying because they were afraid of what was going to happen. And what they were afraid was going to happen with losing their baby. In New York we do not criminally prosecute women in these circumstances.

So again in my previous job I used to direct a variety of programs that tried to get high risk pregnant women into prenatal care and it was precisely through that experience that I learned there were many women who were drug involved who were eager for treatment and it just wasn't there.

Mr. HASTERT. Mr. Rice, you stated that one of the problems in your hospital is young women coming in, having babies and walking out the door. Obviously, there's a moral, maybe not to anybody else here, but to me there's a moral problem. A moral problem in what motherhood is about, a moral problem about responsibility. A moral problem about responsibility, period. There is also a fiscal problem. The chairman said that somebody has to pay for this. The answer is everybody pays for it. It comes out of everybody's pocket. So it is a social problem.

Do you think if at least somebody told these people this is wrong to do this it would begin to, and that's what law does basically. What's your feeling on this issue?

Mr. RICE. My good friend and I sit together on the Mayor's Committee on Infant Mortality and I believe this new drug crack is so different that we're going to have to do both ways. We're going to have to have certainly treatment centers for those that want treatment, but right now if it puts one in a position they will walk out and leave their baby they're not about to seek treatment. They're not in the frame of mind yet to do that.

So I tend to agree with both there has to be both the carrot and the stick because let me tell you a year ago we did not have this problem. It was not a problem in the District of Columbia until crack came on the scene. Heroin did not produce a generation of grandmothers that were not able to take care of their mothers outside of some other metropolitan area. We did not have a problem.

The other point I'd like to make is that I do not believe that the states yet understand the severity of the problem. I think it's going to take a federal initiative to get the word out because even in our own city where we are compassionate there is not yet an understanding of the enormity of this particular part of the problem and I believe you will find in many other cities as this crack moves across this country that our states are not going to be prepared to deal with the problem of crack and especially as it relates to these abandoned babies.

Mr. Hastert. We talk about prenatal care and these types of things. We could have WIC programs, which is a great program and that that type of prenatal care programs is the one we need to have. But we can have them in infinity if people don't want to become part of this process; to me it's an enigma. How do we begin to solve the problem? We've got all kinds of social service issues out there and programs available for people, but if we don't take the first step and say, "listen, this is wrong," we shouldn't do it. When you do it, there's some kind of distinction to try to move people into these types of programs.

Let me ask you just one more question. We talked about babies, children, some healthy, some not very healthy that take 50 or 60 days to be able to be put back on society. And there are a lot of mothers that just walk away from those children. This committee, under the leadership of the present chairman, has talked about foster care and expediting foster care. Would those types of sanctions help if there were some laws that said, "listen, we need to free these kids up so we can get them out of the institutions and into caring families when they're abandoned like this"?

Mr. Rice. Currently there are not enough foster care homes to take care of the problem. And I feel that there has to be an intermediate step taken before a foster home is considered, that this child, that the Grandma's House and other kinds of homes that may not be looked upon by social services as the most appropriate place for these children. We have to rethink and go back and maybe have a new understanding that we're going to be months and years in terms of placement of these children because they're not the most wantable product. And that I come down on another side and say there has to be an intermediate step prior to placement in foster or adoptive care, that is less expensive and more home like than a hospital and that that can be done and it should be done and it's not to say that I'm for returning to the group homes we had years ago but unless we hurry up and develop more foster homes that will be the most cost effective way to attack the problem in a more humane way.

Mr. Hastert. Or, possibly expediting terminating parental rights in some cases. Are there adoptive homes for these kids?

Mr. Rice. We were able to get one article in the paper and I did receive a call in reference to adoption. I think we've had good experience in D.C. General where the nurses themselves want to and have adopted children so that maybe she will speak to that. There are people that want them but it takes so long to get through the process that it is just criminal.

Ms. Gallen. I could talk a bit to that, we were talking earlier about who's paying for this and everything. Just to give you some examples, we are so unprepared. Budgets are not prepared to take care of the needs for different kinds of equipment. We've had our nurses in the nursery literally raffling off pies and cakes to get enough money to pay for cribs, bigger cribs than we usually have. All of us are buying things, going to different stores when they have sales. Nurses are bringing clothing home and washing it themselves. Our laundry is not set up for taking care of small things.

Some of the nurses have been able to take some of the babies home but generally speaking the time that it takes as Haynes was saying goes on for long, long periods of time and while you're waiting for that you've got another six or eight babies that have been born backing into the system because it's growing while you're looking at it. It really is.

Mr. **Hastert**. I appreciate your concern. I certainly appreciate the testimony of the whole family. I think it just underscores, there are two lines of victims. Some of these victims may be born, and some may not be born but we need to look at their care. We need to institute, if we have to institute laws to make sure that their rights and their life is protected and we don't do that. Thank you, Mr. Chairman.

Chairman **Miller**. Mr. Rangel.

Mr. **Rangel**. Thank you, Mr. Chairman. Since we're talking about trying to control the spread of the AIDS virus and drug treatment, I think it's appropriate that we discuss needles, but not just sterile needles. I think you have to talk about needles as being part of a program. When you find political leaders and mayors not having any program, not even willing to ask for any money for a rehabilitation program but are able to find monies for clean needles I think that is absolutely wrong.

But when the excuse for having the needles is to induce people to come forward for treatment it even gets worse if you know that you don't have the slots for the treatment.

Where we need help from the doctors is the second argument that in my city has given for this program needle program. One is to induce people to come forward to ask for treatment that doesn't exist. The second is so that they can test whether or not sterile needles reduced the incidents of the AIDS virus.

Now I'm asking the doctors, first of all, if you're going to have a test, is it necessary to keep a group of people on dirty needles? If you really are inducing people to come in for treatment and everybody got treatment would that not destroy the control group in order to test whether or not it makes any difference at all? Don't you really have to make an effort to keep those people, at least some people, on dirty needles?

Dr. **Halfon**. I think that the studies could be done because there are enough people that could serve as a control group if you were, have needle exchange programs just for research purposes. I feel like I don't want to make other suggestions about research and epidemiologic consideration since, I am a physician and my expertise is really in pediatrics——

Mr. **Rangel**. I don't think you need to be an expert to find out. If you've got a group that you're continuously giving clean needles to, and I assume proving some quality control of the heroin that's there but leaving that alone, clean needles and dirty heroin, but how do you determine whether the clean needles are effective? What do you do, go out in the street and check the AIDS virus with those that are not in the program?

Dr. **Halfon**. I don't feel qualified to answer that.

Mr. Rangel. All right. Has anyone ever seen any treatment program for any mother that they may have thought really works and they would like to suggest that to others, where is that program?

Dr. Chavkin. I've seen several.

Mr. Rangel. Can you give us just the names of where they are?

Dr. Chavkin. I'll give you a few in the City of New York. One is the P.A.M. Program. Program for Pregnant Addicts and Addicted Mothers which is located at the Metropolitan Hospital although it's run by New York Medical College. It's been going for a long time. They provide comprehensive services all under one roof so people don't have to chase around the town.

Mr. Rangel. And there's a follow through on how long the person stays on?

Dr. Chavkin. Not only that, if people want to stay involved with the program and get all the help with parenting, child stimulation, early child development, as well as the very critical pieces of job training and educational opportunities for the woman, they've got people who've stayed with them for 8 years.

I think that——

Mr. Rangel. Stayed with whom for 8 years?

Dr. Chavkin. Stayed with the program. In other words, stayed involved with the program, kept coming back.

Mr. Rangel. Did they get jobs during those 8 years?

Dr. Chavkin. They got jobs.

Mr. Rangel. Did they come back as volunteers?

Dr. Chavkin. It's not a miracle cure. I mean one of the things that we have to address is what kinds of jobs are available for people who are undereducated or have been poorly educated so the program does not claim to resolve all of society's ills but they get people jobs at McDonald's. They're now very excited about offering some kind of computer operator training because that offers a little more.

Mr. Rangel. I will invite the Chairman and members of the committee to join with the Select Narcotic Committee on Abuse. We are now in the process of evaluating the modalities and I agree with you that just making, reducing one's habit or eliminating it, if that person is in the same condition they were before they started using drugs, that you do find a tendency to go back on drugs. So we will invite you to join with us again to see how these programs are working.

And I hope you will continue to work with our staff to give us the programs and all of you, really, that have had programs that you believe have been successful because I do know of programs that are ripoffs especially by the medical profession.

Chairman Miller. Methadone programs specifically? Congressman Martinez.

Mr. Martinez. Thank you, Mr. Chairman. It seems to me that there's two very immediate problems. The first is doing something with the babies that have been abandoned and providing services for them that are less costly than what the hospitals are currently contributing.

And the second problem is that you know what to do about encouraging and helping mothers who are addicted and you are able to provide the biggest help in trying to get them to kick their habits, but as Mr. Rangel has just said though, that's only part of the problem. The real problem is trying to eliminate the situation that got them there in the first place. Constantly through these hearings, as that theme is discussed, I hear "there's not enough resources, there's not enough, there's not enough."

Somewhere along the line we're going tc have to decide in this country whether you want to build more MX missiles that are going to sit in the ground or provide more for programs that are making us a healthy country, internally healthy. You know, we spend a great deal of money in places likes Central America helping people kill each other, rather than taking care of the people here at home who have situations that are making them kill each other.

I think we have to determine a priority. What's more important than the problems we have here at home? Are we going to solve everybody else's problems and let our problems go unattended. That's what it seems like in the 7 years I've been here in Congress is happening.

But I'm more immediately concerned right now about the problem of the abandoned children. In California, in fact, in my district in the city of El Monte, there is a facility we call McLaren Hall where they do take in the little infants. I've visited there, and in lieu of a better situation where the child is in the home with his natural parents and developing that bond, there is a certain amount of bonding going on with the volunteers that work there. These volunteers are consistent, unlike so many volunteer groups where volunteers give the time if they can and if they don't feel like working they don't give the time. People that are involved in this program are really dedicated to it, probably because they see these young children, and are rewarded by that great feeling they get from seeing these children go from a very desperate destitute attitude and feeling to a more happy, hopeful one.

And I'm wondering why, while we have so many models like this throughout the country, McLaren Hall isn't an isolated one, why we're not doing more in trying to get the federal government to provide monies to establish these kinds of establishments wherever there is an abundance of problems such as these?

Dr. HALFON. I'd like to differ with Congressman Martinez a little bit. McLaren Hall is the L.A. County Children's Shelter and it's the place where kids are being placed basically because they don't have foster homes for them to go into. Every child development expert in the country all, would state that a group shelter is a second best solution to getting these babies into good foster homes.

In the state of California right now, the number of kids coming into foster care is 2.5 times the rate of the increase in foster homes so that we're putting five and six babies into one home. And what's happening is that the foster mothers can't take care of them. If you put them into something like McLaren Hall where you might have hundreds of babies, you cannot possibly replicate the kinds of nurturing and developmental processes that you need to have to have normal development. What we were actually doing is taking these babies who suffer intrauterine assault and then because of our lack of public programs and because of our lack of initiative in the child welfare system condemning them to institutional care in a place like McLaren Hall which is trying the best possible care and into a foster care system in that does not have enough foster parents, training and support services.

If you can imagine what it's like to take care of a baby getting up all hours of the night and screaming. It's very difficult to care for them. With five babies like this at home, if you think that one foster mother can do that and consistently and give them the kind of love and nurturance they need, it's a tall order even for the most saintly.

Mr. **MARTINEZ**. In the first place I said in lieu of that situation you described. In the second place McLaren Hall is an interim place until they can find foster care or for places that might get them into a better situation. You speak about having five children in a foster care situation. You described crying all night. I have five children. I am the father of five, grandfather of 11 so I have——

Dr. **HALFON**. But they weren't all under 2 at the time.

Mr. **MARTINEZ**. You're right. But they were pretty close. I had five children in the first five years I was married. But the point is, and I was trying to get Mr. Rice to respond to this, that those centers are, I think a valuable intermediate place as an alternative to the high costs of hospital care that is the point I was trying to make. We don't do this because here again we say there's not enough foster homes and these children have to be some place more economical, and cared for in a more economical way than they are in a hospital. I invite you to visit McLaren Hall because I've been out there several times. In fact, the principal, the one time principal who has since retired was a very, very close and dear friend of mine, George Eagate. The people that come in, and there are people that spend all night there, although they are volunteers, give as much love as possible under these circumstances. More than I have witnessed myself in much better situations. When these children are supported in a hospital they should be able to go from the very most desperate kind of a situation to something intermediate to something which is hopefully ideal.

There's got to be a transition, one, from the cost standpoint, two, from the standpoint that economics mandate it.

Mr. **RICE**. I could not agree with you more. You were just restating what I tried to say. My real point is that communities in this country closed up those homes. We went through an era when we said this was not an appropriate place for children that we should move toward single and I suggested to you now that we must revisit that. There has to be more of these intermediate type places until we can either create more foster homes or more adoptions and I do not believe the local governments at this time are yet as concerned or aware of this growing problem and my whole point is to illustrate exactly what you described as being something a lot better than being in intensive care, hospital nursery or anything as institutional as a hospital. It's not the appropriate place for it.

Mr. **MARTINEZ**. I agree with you that the idea is——

Chairman **MILLER**. Better agree quickly.

Mr. **MARTINEZ**. Okay, the mentality that exists that we have to have the best or nothing is not really a realistic one.

One last thing. You mentioned the carrot and stick. I believe the only problem with that mentality of the stick and punishment as the way to get people in line is that in certain situations it is not the best way, and it will never work. It's just like raising your children. You can't beat the devil out of them every time they did the least little thing wrong. Sometimes you have to understand they're growing up and that there's a time and a place for certain kinds of punishment. You have to be judicious if you're going to get the best results. I think that we have had programs in the past such as this with alcoholics.

There was a time when we used to mandate, after these people were picked up the third or fourth time for alcoholism, that they either go to jail or go to a farm to get cured. Somehow the courts found that that was unconstitutional, we can't do that any more. I think that's wrong, and I don't know how it came to be unconstitutional, but in many cases that is the kind of answer we need. When you find somebody doing wrong you say, "look here's the punishment, you are convicted of a crime, now we will give you the chance to rehabilitate yourself or do the time."

I think most people will take the rehabilitation, and if they do and we're not successful in every case, well that's the tragedy of the situation. But I think more times than not we are successful.

Chairman Miller. Mr. Smith.

Mr. Smith. Thank you, Mr. Chairman. I apologize for being late. I just, I'm not so sure I have a question as just a comment. I'm reminded of those old days, though, that a member from California was just remembering. In Vermont, anyway, in the old days one of the things we did with people we convicted of crimes was to take them to the edge of town and to tell them to get lost. It worked very well as long as there was two thirds of the country that was undeveloped. However, it declined in popularity both on the sending and receiving ends within the last 30 to 50 years.

I don't know what that means. I hope we have agreed that we could and must balance concepts of treatment, concepts of penalty and I think the initial statements we got to find, we got to strike the right balance and I think you said that so let's agree to that.

And that we need more treatment facilities and I keep looking at, I don't know what the situation is like, I think Vermont, I think rural areas are somewhat different in many regards but we have empty beds in our hospitals. We have space, we have facilities, we have underutilized facilities simply because the function that the institution, the role that it plays in society is changing because the society around it is changing so the traditional care giving 20 years ago isn't traditional and care giving today is that we've got capacity and it isn't being used.

Chairman Miller. Maybe there's some potential that we can revert to in Vermont.

Mr. Smith. And I'll run it. I really, along with treatment and penalties I guess the thing I want to add, Mr. Chairman, to this is having read and listened to even in a limited sense I feel that I'm listening about a report, listening to a report from Dante's Hell, I mean I really, I don't think there's any way for those of us who through reasons of privilege or circumstance or geography or profession haven't walked in those shoes that we can conceive of what, I keep trying to push my conception out to a point where it encompasses the enormity of what you're describing and I'm not, I haven't gotten there yet.

I think we, when you look at the role that firearms play quite frankly in urban areas, when you look at, to me we're describing something that is entropy, extreme entropy, I don't know if you can have extreme entropy, but I didn't know what that word meant a few months ago. So I went and looked it up because someone else used it. It means nothing is happening. It means there is no basis in the organism for improvement because there is no base to it. There's nothing to build on.

And you look at the situation in schools and in other social organizations, you look at the collapse of local economies within urban areas. There are not any local economies and we always think of cities, great big ones like New York as having an economy or the District. It's not. It's a collection of diverse, or used to be, of diverse local economies in that area. We're losing them and so what we need to figure out somehow is to add the fundamental ingredient of hope.

In other words, if people do not have hope when we've got the penalty treatment mixed right and we're using our facilities, somehow we've got to figure out how to crank back and the only thing that makes this country work right which is people who sense an opportunity in their future, personally, and then they will have a much better likelihood of taking care of themselves and taking care of their children and doing all the things that we want them to do, whether it's Rice or Martinez or anyone.

I'm trying to conceive of it as a war that's an old, I don't mean it the way we used to talk about it but if we took all these different problems and we divided people into two teams and we realized that we're killing more people here than were dying in Afghanistan or on the West Bank or in Northern Ireland or wherever it is, there's something that is the equivalent of a collapse and if we could describe it as a conflict and then we could assign values and ways that this society understands. I just don't think anybody regardless of party or geographical region would accept it.

Chairman MILLER. Thank you. Mrs. Boggs.

Mrs. BOGGS. Thank you, Mr. Chairman, and thank all of you on the panel for your remarkable testimony. And for all of the years of experience that are represented in your presence.

I was very interested in the fact that you, Ms. Gallen, have seen so many changes. I suppose I went into the volunteer movement and working with children and families and child services about the time that you went into nursing and I know the remarkable changes that you've seen and the remarkable ways in which you met those challenges.

But as you pointed out in your testimony that you said throughout the entire nation there's a growing concern about chemical substance abuse and its attendant ills including increased violence, crime, child abuse and maternal mortality, sickness and death. I think that's why we find a variety of views expressed here and all over the country and how we address all of these problems in a comprehensive manner.

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And that perhaps as has been suggested and his great overview of laws and of reactions of judges and legal entities that Mr. Parness has given us, that sometimes you have to measure out constitutional values with some preventive situations that can cure an overall ill that affects the entire community.

I was mostly pleased because all of you emphasized that we have to give more importance to the ever growing difficulties that we find and in this war that we're going to be conducting that we have as you suggested, Dr. Rice, the increased visibility on the part of babies and the other innocent victims of the war because if we do that then perhaps we will emphasize all of the other programs that all the rest of you are suggesting and to have each of you come to the conclusion that we have to have a comprehensive manner dealing with all of these problems is really a very gratifying conclusion for all of us on this committee, grappling with these problems now for a long time and being helped by testimony from the presence of your experience and great knowledge. And for your care and your concern.

As we talked about comprehensive programs and relief of comprehensive approach we talked about a great many things. We talked about the increased incidents of Sudden Infant Death Syndrome, about the increased incidents of maternal mortality, about the increased incidents of learning disabilities in the older child and it began to occur to me that what we needed to do was to reach out to all of those organizations that work at these various regards and to include them in the comprehensive approach.

I was very, very pleased that Dr. Chavkin that you pointed out the program of the Odyssey House day care center because I was on Odyssey's board in New Orleans for many years and I was very supportive of the program but day care is a problem that all of us now are concerned with in every regard, for every kind of parent in the United States and the making available day care possibilities is really essential to so many problems of the easing of so many problems in our society.

I guess what I'm trying to say is can you see, all of you and each of you, opportunity to use the increase and visibility of the children who are the victims of this war in which we are engaged of bringing all of the different groups, the different associations, the different medical treatments, the different judicial and legal approaches, the groups that are concerned about Sudden Infant Death Syndrome, it's a big and active group. And each of the other kinds of difficulties that are addressed by organized groups, bringing these together to help you and us and the country in this fight? Since you stressed preventive means, would you——

Dr. **Chavkin**. Certainly. I think that what we do need if we're going to proceed in that direction, however, is some coordination so that we have some kind of rational planning for different localities and we don't stumble over each other but rather really complement one another in these efforts.

One of the things that I'm concerned about when I hear people talk about sanctions is the fact that I feel that the women in these circumstances are truly between a rock and a hard place. I mean if you've got no treatment program that will accept you, no place to leave your child when you finally find a treatment program that will take you in, no home, you know, and then for somebody to suggest that indeed what you deserve in the circumstances is punishment, it feels as I said like a rock and a hard place, very hard to imagine somebody maneuvering positively forward.

Mrs. BOGGS. Unless you have some sort of restraints and constraints think how lucky the little 13 year old was who was picked up because she was transporting drugs and fortunately for her she was picked up because she will have an opportunity to come to a hospital to deliver a baby. But there has to be some kind of restraints, some kind of legal restraints.

Dr. CHAVKIN. I would distinguish between the sale or entrepreneurial end of drugs and the user. It seems to me those are different experiences. Also that 13 year old was another example of, I have a little bit of trouble when we all talk about the babies as the only innocent victims. I mean of course they're innocent victims but I think so is that 13 year old. She's 13, she's had two kids and she's H.I.V. positive. I mean some of those babies who we're very worried about today are going to be here very soon.

Mr. PARNESS. May I say something about sanctions? The assumption seems to be that if there is a criminal law prohibiting certain kinds of conduct, there's automatically going to be prosecution.

I just think the evidence doesn't suggest that. There has been a provision in the California penal code for years that has permitted, on prosecutorial discretion, the prosecution of either a prospective father or prospective mother who willfully fails to provide care to an unborn child. That provision is very seldom used.

On the other hand that provision is looked to as providing guideposts for people who conduct themselves in the state, for suggesting to people what the state views as being important. I think the law promotes certain kinds of positive social conduct. So I think when we talk about punishment we don't necessarily talk about criminal laws that are fully enforced. In fact, we have evidence suggesting that they're very rarely enforced but they have a positive influence, and I think for that reason their growth ought to be seriously considered.

Mrs. BOGGS. Ms. Gallen, you have experience in Africa. What sort of advice from that experience could you give those of us in the United States?

Ms. GALLEN. I guess almost none at all. The family is so intact over there that, I worked in North Africa and West Africa both with Peace Corps and it's a whole different story. Also this was 25 years ago and our families also were different 25 years ago.

It's just a very, very intact situation. Whole families raised a child together in the compound. It's a beautiful, beautiful situation. We could certainly learn from what they have but our problems are altogether different.

I just fail constantly to think in terms of thinking about prosecution or any kind of that type of approach to the problem. This crack most especially is a thoroughly medical problem and when you can take anything at all and say 90 percent of the people who start out with it are going to become addicted to it and that their addiction will become so profound that in months you can watch these people go down then this is altogether different.

These women who I talk with in jail they too are very interesting in how they describe their addiction. It is different. It's very different and we have got to help people and the women are not against help, there's just no place to help them, that's the problem. It's going to take a lot of money to really help them, to really keep them, they come to us. We had a woman two weeks ago who we finally were able to admit because we could find a medical reason, this was on a Friday afternoon. The woman before our eyes was beginning to go into withdrawal. She was admitted and the next Monday, interestingly enough, she had not left the hospital but the word had gone out more than likely because Monday afternoon we had three women who wanted us to admit them. So women are begging for help. They don't hate their babies, they want them alive and well and happy but they can't help themselves, it's so profound that they just can't do anything. To say that's a weakness, who's perfect?

Maybe the first time you shouldn't have taken it but most people are so young, I don't know how you hold a 13 or 14 year old totally responsible.

Chairman Miller. Mr. Sarpalius.

Mr. Sarpalius. Thank you, Mr. Chairman. I apologize for being late. Unfortunately, I have two committees going on at the same time. But I'm curious if any of you have any raw statistics as to what percentage of mothers that come to you that seek help are turned away because of lack of treatment facilities?

Dr. Chavkin. I presented some New York City data before which is that in New York City 54 percent of drug treatment programs categorically refuse to treat pregnant women and those proportions get higher when you add more detail. In other words, what was it 67 percent refused to treat pregnant women on Medicaid.

Chairman Miller. 87 percent.

Dr. Chavkin. 87 percent of pregnant women on Medicaid who were crack involved.

Mr. Sarpalius. Eighty-seven percent of——

Dr. Chavkin. Refused to treat pregnant women on Medicaid with crack problems.

Mr. Sarpalius. So you're saying they were basically turned away?

Dr. Chavkin. Definitely turned away.

Mr. Sarpalius. And I've read some of the statements and do you have some wish lists of what you would like to see Congress do. You talk about rehabilitation, treatment or social workers, different things like that? In your opinion, Doctor, what would you put at the top of the list?

Dr. Chavkin. Treatment.

Dr. Halfon. It has to be treatment that's different from the treatment that we've been doing in the past. We have treatment models that are based on men who have heroin problems, that's what our treatment models are based on and it's different than dealing with women with crack problems.

Dr. Chavkin. And women with children.

Dr. Halfon. And women with children. We have to have a whole new conception. We need to come up with a policy that addresses the long-range implications and the fact that these drug-exposed babies are going to be the crack mothers 13 years down the line unless we have treatment that's comprehensive and not just throwing money into the same old treatment programs. We are going to be in big trouble, and I think preventing these long-term effects is the real task at hand.

Mr. SARPALIUS. Mr. Chairman, I could ask a lot of questions but I know we're pressed for time and I appreciate that.

Chairman MILLER. I don't want to cut the members off from questions. Let me just say this, that I guess what bothers me is that I very often see policy makers reaching for sanctions out of frustration. We really cannot sit here today knowing what we're going to do over the next few weeks with respect to the federal budget and agreements and decisions that have been made between the Administration and the Congress and say that, if we wanted to, we're willing to take care of this problem, because we're not. So what we will do is try to suggest that we can take care of this problem by sanction.

The interesting thing I note is this: Almost all of the activity that's been described here is already against the law. The use of drugs is against the law, the abandonment of a child is against the law in terms of abuse and neglect, if you walk out of the hospital you're abandoning your child. Almost all of these. Now there's the area that is now being brought into conflict for a whole lot of reasons, some drug related and some not, regrading actions against the fetus. But essentially you have adult populations. Prostitution is against the law, in some states use of needles is against the law, all of these activities are already against the law. Sleeping in the streets is against the law. There's no indication that any of these laws have stemmed the flow of eligible individuals for the problem we're now talking about.

And you're quite correct, you hope that you would have made the first decision not to take crack because what people have told Mr. Rangel's committee and this committee is that the first decision to use crack can be a death defying act right there. That first choice, it's different from marijuana, a little different than other drugs, that using it once alone may end up in addiction. But they didn't, they didn't make that choice. Now we can do as we're doing now and we can simply impose long-term punishment either by neglect or by intention on those individuals. But again I don't see where that helps. We've already tried that. We say, well we want to balance the sanctions and treatment. However, we don't have any treatment and the list of people who are getting turned away is in the hundreds of thousands, maybe in the millions, when you combine these systems of affected people. And the people who are getting treated are in the tens of thousands, maybe, and most of that treatment is a single shot and most of that treatment is not comprehensive or long term in any fashion.

So the notion now is that society is going to make a determination that we're going to make you a more intensified criminal. It's like when we get into the drug debate, we decide that to kill a narcotics officer requires the death penalty. Why not killing anybody, first degree murder? Why do we now change this around? Only because we're trying to pretend to the Nation that we're going to do something about the problem.

And finally let me just say what this committee has learned and I think the ventures that Mr. Rangel is about to embark on narcotics are so important because we in fact do see, as George Bush said, a thousand points of light. We can travel around the country and show you in almost every state, every setting, a program that demonstrates that it works, that reduces the level of participation in one of these antisocial behaviors, but we're always talking about service to 10 people, service to 20 people in a city of 10 million. They service 100 people and that's true whether they're the children, the babies, the mothers, the fathers, what have you. And so the notion that somehow we've tried this and failed doesn't wash. All of the evidence suggests that we haven't tried it and failed because for 10 years no treatment program has been expanded. No treatment program that I know of in the nation has been able to meet its case load. None. Nada. That's the program we can't find. Except maybe in Vermont.

But other than that we can't find the successful programs that say, "gee I have a vacancy, send me somebody." They all say they have waiting lists, and as pointed out in a recent article on this question of sanctions, Ann O'Reilly who is the San Francisco Director of Family and Children Services says she'd feel different about sanctions if mothers were walking away from treatment. She says they're not. They're walking away from waiting lists.

And the sad history of this committee is that one of the things we've documented is that every successful mode of treatment has a waiting list that goes into a minimum of months and now we're asking a person who's addicted to remember their appointment. Most people have problems with their anniversaries and their birthdays and their spouse's birthdays and the children's birthdays. We want a crack-addicted teenager to remember four months from now they have an appointment. That's treatment? I don't think so.

We're going to have to confront the notion, Mr. Rangel is sitting here reading about how we're spending $61 million a day on incarceration. My state is building four new prisons. My county is building a brand new prison. We just had a brand new prison. We can't cut the ribbons fast enough. And I think what that suggests is we're losing. But we've tried essentially a decade of this mode which is intense sanctions on almost all behavior and yet there's no indication that we're changing the behavior.

Mr. PARNESS. May I respond to that?

Chairman MILLER. Sure.

Mr. PARNESS. I think you've assumed that there are laws out there that exist that protect potential human life. They're just not there.

Chairman MILLER. No. I said with the exception of that notion. But before you get to that notion the person has already made the decision to violate a whole series of laws that impact their potential life, like the loss of their freedom, maybe the loss of their life and now we're suggesting that just one more level of sanctions will free this nation from this scourge.

Mr. PARNESS. First of all, let's make sure we understand what sanctions are. Sanctions may be the punishment involved in a criminal prosecution which looks back in time. That's one form of sanctions. I agree, that's not a very worthwhile undertaking if that's the whole thrust of the sanctions against pregnant substance abusers. But there are other forms of sanctions that involve coercive conduct, for example intervention by the state prior to birth to try to prevent disabilities at birth. There's a dearth of state laws that allow state agencies to intervene in those settings. I think that's a shame. I think as well when the Vaughn case out of D.C., when the judge took into consideration in issuing an order regarding terms of probation the fact that the woman was pregnant and the fact that if he treated that woman as he would treat a woman who was not pregnant there would be severe and long-term damage to some future born child, I think it was not as illegitimate as was suggested earlier for the court to take that into account, as it is not illegitimate for the court to take into account in terms of probation the possibility that if a particular individual is not incarcerated for some time, he or she is going to go out and blow somebody's head off. It seems to me to be not very different.

The fact that we don't recognize the legitimacy of those kinds of undertakings, however controversial they might be——

Chairman MILLER. Listen, I understand what you're saying. I'm suggesting that that is fantasy. Because the woman that you're seeking may not make contact with this system until she shows up in the emergency room for delivery so that fetus has been addicted for 9 months. Or six months. And after you decide you can catch her in the first trimester—first of all halleluia because it will probably be a better chance of getting prenatal care than any chance she has in the system—you're going to put her in a jail, you can't keep the jails drug free.

So we're talking about the notion that we're going to take this woman away to society's breast and we're going to harbor her in a fashion that will change the outcome of the pregnancy in her life. That program does not exist in America today if you wanted to use it now.

That's the distinction I'm trying to make. It's not an argument whether or not these things should be against the law. They should be against the law. These are antisocial behaviors that have wide ramifications for the individual and for others and in the case we're talking about today for someone who has no say in that behavior. But if the last act is that you show up at the hospital door and you go to prison I suspect another decision with be made. One of the things that has amazed me in this committee is I learn new terms. We've had "sandwich generation," we've had "homeless children," we've had "intact families." Now we've got "toilet bowl babies" again which suggests that women will make the other decision because if going to D.C. Hospital means you're going to jail I think you're going to finally make in your drug-induced state the decision to not go to that hospital.

That's what concerns me. We have dealt with child abuse in the most dramatic fashions and we have a 60 to 70 percent increase in child abuse. That's what worries me about the notion that Congress just reaches for the sanction and we're off and running convincing people that we've done something and one of my colleagues may want to respond because they think I'm crazier than hell, but that's the system.

Mr. **Smith**. I don't think for a minute you're crazier than hell, Mr. Chairman. I would only observe——

Ms. **Boggs**. Not even Doc is.

Mr. **Smith**. I'll pull it all back and start over. I would only observe that at least in part I really think our language is failing us here. And your use of the words coercive to talk about positive interventions really, either I'm misunderstanding you or really the language you're using doesn't in any way reflect what it is you're trying to suggest. I'm not here to coach you on how to talk but to say "not illegitimate" as opposed to a program.

If you want to talk about program intervention that involves ways to bring the state and to pay for the state to be involved with families and women which might include treatment, might include all sorts of things so I would only observe to a certain extent that where we get totally mired down in the question of penalties which is the way this whole, the way we put it on the table, then I hear you really not talking about what I think of when I think of penalties which is sending people to jail.

So I somehow think the conversation has suffered a little bit from the point of view that we're not being helped by all the language here and as I see through the language I see in effect, an attempt of the judicious balance that you were talking about before and that appropriate intervention may be support and treatment than the kinds of things that everybody else is saying don't exist.

Mr. **Hastert**. I have to come to the protection here of my constituent, I guess. We talk funny 50 miles west of Chicago and I guess maybe "not illegitimate" might mean "appropriate" depending on where you're coming from.

But I think the point of this issue and the point of discussion here is that maybe if there's a leverage to get people into programs that are helpful, and if they're appropriate, and you can do it, then maybe we ought to try it. And it's not necessarily saying that you're going to do it because there's a law to put somebody in jail, but because there's a law that says this is right to do; society thinks it's right to do and we ought to do it.

Chairman **Miller**. I can't argue with you. That's very effective. We use that in Santa Clara County in spousal abuse. We say we're going to arrest you for beating your spouse or we're going to arrest you for sexually abusing your child. Now you get a choice. You can go to jail or go to treatment. The difference is Santa Clara County has a treatment program for every man that's arrested under those circumstances and in fact family reunification takes place in a large percentage of cases.

But there's a treatment that you can do that to. Right now you can have all this but there's no treatment because we're not going to spend the billions of dollars that are necessary.

Mr. **Hastert**. I guess my point is, Mr. Chairman, is you just can't look the other way and say this is not wrong to do, and then say, "my gosh, here we have this problem and how are we going to solve it?" We have to recognize that there are problems. We need to say at least in our inadequate "infinite wisdom," what's right and what's wrong and then try to solve the problems too. It's not an "either/or," it's an "and" problem.

Chairman **Miller**. Well you did it, you got us talking here. Thank you very much and I'm sure this is not the last that we'll be calling upon you to help this committee out and to help Mr. Rangel's committee as the Congress struggles with this because we got to figure out some solutions. Ms. Boggs is on the appropriations committee and we can tell her where to spend the money or ask her I guess is the term we use this time of year.

Thank you. The next panel will be made up of Sue Trupin who is the "Grandparents as Parents" Founder and Cofacilitator from San Francisco General Hospital; Toni Shamplain who is the Director of Addictions and Preventive Health Services from Miami, Florida; Carol Cole who is the Child Development Specialist from Los Angeles, California and Lucia Meijer who is the Substance Abuse Specialist from Seattle, Washington.

Welcome to the committee. Sue.

Ms. **Trupin**. I'm Sue Trupin.

Chairman **Miller**. Let me say on behalf of Congresswoman Pelosi who wanted me to make sure that I provided a welcome from her to you, to the committee, what is now this afternoon. We really appreciate you taking your time to come and talk with us. She wanted you to know that also. She appreciates that. We'll start with you. Please proceed in the manner in which you're most comfortable. Your full statements will be placed in the record in its entirety. You may wish to comment on something that you heard from the previous panel by members. You also are free to do that but you can see the extent to which you can summarize so that we can get into this with you.

We appreciate it. Thank you.

[Prepared statement of Hon. Nancy Pelosi follows:]

Prepared Statement of Hon. Nancy Pelosi, a Representative in Congress From the State of California, With an Introduction for Ms. Sue Trupin, RN

Mr. Chairman: I am pleased to introduce my constituent, Ms. Sue Trupin. Ms. Trupin is a nurse who will discuss a very important and successful program we are fortunate to have in San Francisco, "Grandparents as Parents." I am confident Ms. Trupin will provide the committee with important and valuable information regarding perinatal care and substance abuse. Thank you, Mr. Chairman, for your time and for the opportunity for Ms. Trupin to testify before the committee.

STATEMENT OF SUE TRUPIN, "GRANDPARENTS AS PARENTS" FOUNDER AND COFACILITATOR, SAN FRANCISCO GENERAL HOSPITAL, SAN FRANCISCO, CA

Ms. **Trupin**. Good morning. Thank you Mr. Chairman and Mr. Bliley for inviting me here today. My name is Sue Trupin and I am a Registered Nurse in the Adult Medical Clinics of San Francisco General Hospital and I'm presenting this testimony on behalf of myself and Dr. Doriane Miller, an attending physician here with me today and also from San Francisco General.

I've come here to bring your attention to a largely unacknowledged aspect of the crack cocaine crisis, namely the part played by grandparents who in response to the drug abuse of their adult and adolescent children have assumed parental responsibility for their grandchildren. They have assumed this responsibility in an effort to maintain the unity of their families and out of a reluctance to relinquish these grandchildren to the foster care system and they do so in an atmosphere of violence on the part of their adult children and in the neighborhoods around them.

As health care providers we have observed the negative effect this enormous stress has on these grandparents and not surprisingly we have seen their symptoms of chronic illness worsen. Out of concern, Dr. Miller and I started a support group for grandparents raising their grandchildren. We meet weekly at a satellite health center in Bayview Hunters Point, San Francisco's black neighborhood most hard hit by the crack crisis. Our hope is that by bringing these individuals together it will decrease their sense of isolation and make available to them options and resources of which they may not have been aware. We schedule speakers addressing a variety of issues such as legal and welfare rights, child rearing, drug abuse and codependence. In addition, it is a goal of this group to gather political influence in an effort to amplify resources to this population.

The 58 grandparents referred to our group have all been black women and they range in age from 42 to 72. The majority have worked all their adult lives and have quit their jobs to care for their grandchildren. Some of the younger grandparents are on disability for medical problems, others had begun attending junior colleges in the hopes of completing their education and finding work in new fields. Many of the elderly women are disabled by chronic illness and are not exhausted from caring for infants and small children. In my testimony I describe the ways in which grandparents who are caring for the children are subsidized by foster care and by Aid to Families with Dependent Children and I want to go directly to the subject of unsubsidized grandparents. An undocumented part of this phenomenon.

Outside the formal system lies the grandparent who has assumed either partial or full responsibility for their grandchildren and yet is receiving absolutely no assistance.

The Child Abuse Hotline, a service of San Francisco Children's Emergency Services, gets about twelve calls a week from grandparents claiming neglect of their grandchildren on the part of an adult child using drugs.

Due to the huge numbers of cases and the shortage of workers this is basically a triage situation in which Children's Emergency Service will intervene only in the most extreme cases, those in which they are convinced that the judge will move for removal of the children from the home. Often, however, there is a gray marginal area in which you see the addict parent functioning sporadically. The child is getting to school two days a week, the parent manages to make her appointments with AFDC, there is stale bread in the refrigerator. This sort of case for removal will not win in court and the investigator knowing that will warn the parent, recommend drug treatment and make the decision not to intervene.

What we are then seeing in really astonishing numbers is grandparents unsatisfied with the response of the Emergency Services, begin to assume responsibility for their grandchildren either partially or completely. They are reluctant to apply for AFDC for themselves because to do so is to take the check from the addict parent and this confrontation constitutes a virtual declaration of war with a violent and desperately ill individual.

J.B., a 72 year old arthritic grandmother, told us when she took her grandchild into her home and registered her in school, the AFDC check which her addict son had been receiving began coming to her home. J.B. describes how when this happened, her son looked like he was going to kill her and in fact, she has not challenged his right to this check to this day.

L.V., like many of the grandmothers in our group, has her grandchildren for part of the month. When she has them seems to depend on when the check arrives and the drug use pattern of the addicted parent who may drop the children off and not come back for a week. She will then appear and demand to have the kids back, only to bring them to an entirely new place, a motel or a shelter, with a new assortment of characters and a new series of disturbing events.

It is heartbreaking to hear these women describe the terror they feel for their grandchildren and their complete lack of power to intervene effectively on their behalf. It is not surprising then that we are seeing these women in our medical clinics with seriously aggravated symptoms of chronic illness.

The larger picture. The nature of the drug. We in the health profession, especially within a county system, are accustomed to witnessing the ravages of alcohol and drug abuse. It is important then to take note of how crack cocaine is different from any drug we have ever seen. The most remarkable and hideous aspect of crack cocaine use seems to be the undermining of the maternal instinct. Last year, an addicted mother in Oakland was found to have smoked crack at home during labor and between the delivery of twins, both of whom later died. This type of behavior indicates total obsession and extraordinary chemical dependence.

Government Accountability. Government leaders must take a harder look at why it is that so many of our citizens are filled with such hopelessness and behave as if they have so little to lose. Nowhere is this more strongly felt than in the black community. What we're seeing in inner cities amongst poor young blacks is a dramatic failure to thrive. Last week, a national conference on crack cocaine use was held by San Francisco's Glide Methodist Church and it was aptly titled "A Death of a Race." The desperation felt by this population is fertile ground for drug pushers and I include the alcohol industry in this group.

You must ask yourself who are the real pushers of these drugs? And from where are these drugs coming? If an impoverished, demoralized population is at high risk for drug dependence, are there not industries, institutions and systems in place which promote that dependence?

As for welfare, black leaders are beginning to speak of AFDC to addicted parents as an instrument of codependence and therefore a misuse of funds. Most people receiving welfare need this money to feed their children and to pay their rent. And it is unclear what opportunities and options really exist for these impoverished and uneducated recipients. For most, reality is unrelentingly bleak.

Recommendations. We recommend the redistribution of funds for increased child welfare services and restructuring of the system in order to lower the threshold for intervention and to increase monitoring of reported cases.

What is referred to as neglect and therefore not grounds for intervention would, if it were your grandchild or mine, constitute abuse. Children's rights to adequate nourishment, shelter, education and health care are not being maintained by the current system and intervention needs to occur at a much earlier stage.

We recommend increased rehabilitation services, especially residential treatment programs focusing on reunification of the family.

And lastly we recommend acknowledgement and increased support services to the grandparents and family members assuming care of the children victimized by this crisis.

It costs the city of San Francisco up to $4,000 per month to place a child in temporary shelter and by caring for these children, grandparents and family members are saving the city an enormous amount of money. These women are the real heros in the community. They in the midst of an intolerable degree of violence and despair are upholding the most cherished American institution, namely the family and we must give them recognition and support.

Without this support the stress of their burden will soon become too immense to bear. They will become too ill to care for the children, traumatized by chronic neglect. The responsibility for these children will fall onto the shoulders of an already overburdened system resulting in increased economic cost to the government and an immeasurable loss of emotional and psychological well being.

Thank you.

Chairman. MILLER. Thank you.

[Prepared statement of Sue Trupin follows:]

PREPARED STATEMENT OF SUE TRUPIN, R.N., FOUNDER AND COFACILITATOR GRANDPARENTS AS PARENTS, STAFF NURSE, ADULT MEDICAL CLINICS, SAN FRANCISCO GENERAL HOSPITAL, SAN FRANCISCO, CA

Good morning.

Thank you Mr. Chairman and Mr. Bliley for inviting me here today. My name is Sue Trupin and I am a Registered Nurse in the Adult Medical Clinics of San Francisco General Hospital. I am presenting this testimony on behalf of myself and Dr. Doriane Miller, an attending physician also at San Francisco General Hospital. I've come here to bring your attention to a largely unacknowledged aspect of the crack cocaine crisis -- namely, the part played by grandparents who, in response to the drug abuse of their adult and adolescent children, have assumed parental responsibility for their grandchildren. They have assumed this responsibility in an effort to maintain the unity of their families and out of a reluctance to relinquish these grandchildren to the foster care system and they do so in an atmosphere of violence on the part of their adult children and in the neighborhoods around them. As health care providers we have observed the negative effect this enormous stress has on these grandparents and not surprisingly, have seen their symptoms of chronic illness worsen.

Out of concern, Dr. Miller and I started a support group for grandparents raising their grandchildren. We meet weekly at a satellite health center in Bayview Hunters Point, San Francisco's black neighborhood most hard hit by the crack crisis. Our hope is that by bringing these individuals together it will decrease their sense of isolation and make available to them options and resources of which they may not have been aware. We schedule speakers addressing a variety of issues such as legal and welfare rights, child rearing, drug abuse and co-dependence. In addition, it is a goal of this group to gather political influence in an effort to amplify resources for this population.

The 58 grandparents referred to our group have all been black women and they range in age from 42 to 72. The majority have worked all their adult lives and have quit their jobs to care for their grandchildren. Some of the younger grandparents are on disability for medical problems, others had begun attending junior colleges in the hopes of completing their educations and of finding work in new fields. Many of the elderly women are disabled by chronic illness and are now exhausted from caring for infants and small children.

STATISTICS FOR SAN FRANCISCO

Total number of children in foster care system as of 2/89:	2,412
• Children in custody of relatives who are not legal guardians:	838
• Children in custody of relatives who are legal guardians:	115

In other words, 953 children or 39% of children in foster care in San Francisco are with family members. These numbers do not include those grandparents receiving Aid to Families with Dependent Children (AFDC), nor does it include those grandparents caring for grandchildren but not receiving funds. This latter category is undocumented but constitutes around 35% of grandmothers referred to our group. In the Bayview Hunters Point neighborhood, Shirley Gross, Executive Director of the Bayview Hunters Point Foundation, gives a conservative estimate that 20% of the children living in that neighborhood are being raised by their grandparents.

SYSTEM PROCESS

Subsidized Care

The following is a description of the process by which grandparents as a result of formal court intervention receive funds for care of their grandchildren. These grandparents receive either AFDC, or, if eligible, foster parent status for which a higher rate is paid. Once the child is placed in the grandparent's home, a child welfare worker reviews the case every six months and the parent is given 12-18 months to put her life in order, after which time the child is either returned to the parent or arrangements for long-term placement are made, either by adoption or legal guardianship.

The grandparent on AFDC receives less money than her foster parent counterpart. She must go to the courts to obtain foster parent status for which she is most likely eligible but may not receive. In order for the grandparent to be eligible for foster parent status, the addicted parent must first establish eligibility for AFDC, according to the Miller-Yokum decision. Often the addicted parent has been so out of control with respect to drug use that he or she has not even applied for AFDC.

Problems for this Group

There are special problems for grandparents receiving either AFDC or foster care funds. The first is the frequent and lengthy delays in getting checks. The bureaucracy is very confusing; the need to present documents (birth certificates, school records and immunizations, etc.) may involve multiple appointments. There may be as many as three case workers from separate departments--one for the adult parent still receiving AFDC, another for the child, a child welfare worker, and yet another case worker dealing solely with eligibility and finances. Often different workers say different things, causing endless delays and confusion. Also, relatives appear to have a low priority within the system. They have no advocates and while a group home or an individual non-family member foster parent may even get a lawyer to protest the delay with checks, a grandparent is made to feel as if they are somehow less deserving than a foster parent who is not a family member. A lot of our grandmothers have worked their entire lives, were never on welfare and this process is humiliating to them. The truth is that as middle aged and elderly women on fixed and limited incomes, they need this money and, by caring for their grandchildren, have every right to it.

It costs the city of San Francisco up to $4,000 per month to place a child in temporary shelter. By caring for their grandchildren, these grandparents and family members are saving the city an enormous amount of money. It must be understood that although the grandparents are subsidized, the overall economic situation of the family deteriorates. Most of these women were already employed in low-paying, service-related positions and by accepting new parental responsibilities have had to quit their jobs.

Another major problem facing these grandparents is the continued presence of the addict parent. He or she continues to use the drug and remains in the neighborhood, wreaking havoc in the home of the grandparent. A regular theme from grandparents new to the group is the extent to which their addicted child has stolen everything they ever had of value and then gone on to steal clothes from their closet, appliances, records, etc.

> *P.M. is a 68-year-old great grandmother caring for the four children (ages 7 months - 8 years) of her crack-addicted granddaughter. She has foster care status, but besides dealing with an infant born on crack and an 8-year-old boy traumatized by experiences with his mother, P.M. is forced to endure frequent disruption from the granddaughter who pleads to see her children and whose children plead often to see her and then when she is in the home, steals money from her grandmother's purse and even persuades her 8-year-old son to steal for her.*

We often hear, "I accept that I have to take care of my grandchildren, but I cannot care for them and handle their mother too."

N.S., a 52-year-old grandmother with two grandchildren (2½ and 6), describes her addicted daughter sleeping on the street in front of her house and coming to the door where she opens the mail slot and cries out to the children. This grandmother just received a three-year restraining order but it took a long time and it's to be seen how well it will be enforced.

The shortage of outpatient programs and the virtual absence of residential treatment guarantees that the addict remains ill and a continuous source of turmoil and disruption to the family.

Newborn Babies

With respect to newborns with positive toxicology screens, Children's Protective Services maintains ongoing supervision and either the baby is separated from the mother or a conditional arrangement is made stipulating that the mother enroll in a drug treatment program, maintain regular pediatric visits and reside with a responsible family member. Most often this is a grandparent who in this situation is caring for the crack-dependent infant, is not the recipient of AFDC funds and is living with an adult child under the influence of crack and therefore very violent and volatile. Another frequently seen situation is that in which the infant is separated from the parent and given to a family member who then receives AFDC. The addict parent may have older children who remain with her and she therefore continues to receive AFDC as well.

UNSUBSIDIZED GRANDPARENTS

Outside the formal system lies the grandparent who has assumed either partial or full responsibility for their grandchildren and yet is receiving absolutely no assistance.

The Child Abuse Hotline, a service of Children's Emergency Services, gets about twelve calls a week from grandparents claiming neglect of their grandchildren on the part of an adult child using drugs. Although a report is filed, a shortage of investigators (there are 15 in San Francisco) means that most of these cases are not followed up until a separate incident (i.e., a report from Public Health or from the schools) triggers an investigation and the court then intercedes. Due to the huge numbers of cases and the shortage of workers, this is basically a triage situation in which Children's Emergency Service will intervene only in the most extreme cases, those in which they are convinced that the judge will move for removal of the children from the home. If an investigator goes to the home and finds the children alone and a 3-year-old cooking for a one-year-old or finds physical abuse, then she will file for immediate court intervention, which most likely will result in out-of-home placement.

> *M.W. is a 45-year-old grandmother who received a call from authorities in Florida telling her to come and get her grandchildren. She drove alone across the country and found her 24-year-old daughter weighing 85 lbs. and her 1½-year-old granddaughter taking old MacDonald hamburger buns out of the garbage and feeding them to her 8-month-old brother.*

Often, however, there is a grey, marginal area in which you see the addict parent functioning sporadically; the child is getting to school two days a week, the parent manages to make her appointments with AFDC, there's stale bread in the refrigerator. This sort of case for removal will not win in court and the investigator, knowing that, will warn the parent, recommend drug treatment and make the decision not to intervene, although the case will remain on file with Children's Emergency Services.

What we are then seeing in astonishing numbers is grandparents, unsatisfied with the response of Emergency Services, begin to assume responsibility for their grandchildren, either partially or completely. They are reluctant to apply for AFDC themselves because to do so is to take the check from the addict parent and this confrontation constitutes a virtual declaration of war with a violent and desperately ill individual.

> *J.B., 72-year-old arthritic grandmother, told us how when she took her grandchild into her home and registered her in school, the AFDC check which her addict son had been receiving began*

> *coming to her home. J.B. describes how when this happened, her son looked like he was going to kill her and in fact, she has not challenged his right to this check to this day.*
>
> *L.V., like many of the grandmothers in our group, has her grandchildren for part of the month. When she has them seems to depend on when the check arrives and the drug use pattern of the addicted parent who may drop the children off and not come back for a week. She will then appear and demand to have the kids back, only to bring them to an entirely new place, a motel or a shelter, with a new assortment of characters and a new series of disturbing events.*

It is heartbreaking to hear these women describe the terror they feel for their grandchildren and their complete lack of power to intervene effectively on their behalf. It is not surprising that we are seeing these women in our medical clinics with seriously aggravated symptoms of chronic illness.

THE LARGER PICTURE

Nature of the Drug

We in the health profession, especially within a county system, are accustomed to witnessing the ravages of alcohol and drug abuse. It is important then to take note of how crack cocaine is different from any drug we have ever seen. The most remarkable and hideous aspect of crack cocaine use seems to be the undermining of the maternal instinct. Last year, an addicted mother was found to have smoked crack at home during labor and between the delivery of twins, both of whom later died. This type of behavior indicates total obsession and extraordinary chemical dependence. In the case of mothers in concentration camps and also mothers in the midst of war, the maternal instinct has remained intact. Alcoholics and heroin users do not behave like this. There is no way to overestimate the crisis in the communities where this drug is being used.

Government Accountability

Government leaders must take a harder look at why it is that so many of our citizens are filled with such hopelessness and have so little to lose. Nowhere is this more strongly felt than in the black community. What we're seeing in inner cities amongst poor young blacks is a dramatic failure to thrive. Last week, a national conference on crack cocaine use was held by San Francisco's Glide Methodist Church and it was aptly titled, "A Death of a Race." The desperation felt by this population is fertile ground for drug pushers, and I include the alcohol industry in this group. You must ask yourselves who are the real pushers of these drugs and from where are these drugs coming? If an impoverished and demoralized population is at high risk for drug dependence, are there not industries, institutions and systems in place which promote that dependence?

As for welfare, black leaders are beginning to speak of AFDC to addicted parents as an instrument of co-dependence and therefore a misuse of funds. Most people receiving welfare need this money to feed their children and to pay their rent. While it is felt by some that these funds may also be misused, it is unclear what options and opportunities really exist for these impoverished and uneducated recipients. For most, reality is unrelentingly bleak.

RECOMMENDATIONS

Redistribution of Funds

- Increased child welfare services and restructuring of the system in order to lower the threshold for intervention and to increase monitoring of reported cases.

What is referred to as neglect and therefore not grounds for intervention would, if it were your grandchild or mine, constitute abuse. Children's rights to adequate nourishment, shelter, education and health care are not being maintained by the current system and intervention needs to occur at a much earlier stage.

- Increased rehabilitation services, especially residential treatment programs.

The absence of these programs gives the addict no opportunity to recover. Programs such as Mandela House in Oakland, California and Hale House in New York City focus on reunification and treatment of the wounded family.

- Acknowledgment and increased support services to the grandparents and family members assuming care of the children victimized by this crisis.

These women are the real heroes in the community. They, in the midst of an intolerable degree of violence and despair, are upholding the most cherished American institution, namely, the family and we must give them recognition and support. Without this support, the stress of their burden will soon become too immense to bear. They will become too ill to care for the children traumatized by chronic neglect. The responsibility for these children will fall onto the shoulders of an already over-burdened system, resulting in increased economic cost to the government and an immeasureable loss of emotional and psychological well-being.

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Chairman Miller. Toni Shamplain.

STATEMENT OF TONI SHAMPLAIN, DIRECTOR OF ADDICTIONS AND PREVENTIVE HEALTH SERVICES, FAMILY HEALTH CENTER, INC., MIAMI, FL, ACCOMPANIED BY ESTELLE WHITNEY, M.D., AND TESSIE TRICE

Ms. Shamplain. Good afternoon. My name is Toni Shamplain and I am the Director of Addictions and Preventive Health Services with the Economic Opportunity Family Health Center funded by the United States Public Health Service 330. Executive Director is Ms. Jessie Trice.

It is an honor and a pleasure to be invited to speak to you regarding such a timely issue as cocaine and its effects on women especially pregnant women.

I brought with me today, Dr. Estelle Whitney, as well as Ms. Jessie Trice. What I would like to do a little is to diverge from the written information that you have, the previous panel in my mind was really exciting. But what I would like to share with you which is within your packet is a description of the types of services that we provide, in our city, Miami, Florida.

I think that some of the questions that were raised earlier adds to a possible solution. The Family Health Center being a primary health care center with a competent drug abuse department really won't find that type of a model in my mind that exists in many places in the country. To kind of digress a little bit, my background, my professional background includes the services that I'm providing now as well as having worked out of the single state agency within the state of Florida, the Department of Health and Rehabilitative Services.

Within my background I have also designed treatment programs. It is of great interest to me to go to the Miami area because it provided me with an opportunity to design and implement drug abuse services with the coupling of primary health care.

Some of the issues that have been discussed today which include such issues as teen pregnancy, AIDS prevention. These types of strategies are easy to implement within the environment where you have primary health care settings with alcohol and drug abuse services, so I would like to suggest to the committee that you probably take a look at that type of model, of the coupling of that model.

To give you an idea of the types of services that we provide at the Family Health Center we provide a comprehensive delivery service system which includes outreach, education, AIDS information to nontraditional populations that have tendencies to refuse to enter systems. We are involved in street corner types of activities, working with those individuals as I mentioned that have tendencies not to access systems. We also provide an early intervention/prevention model within two inner city schools. The name of the program is A.L.P.H.A. It's an acronym for A Learning Place For High Achievers. Basically what we do is we work with inner city families and provide a specialized classroom and have four specialized classrooms where we provide individual and group family education and training, not only to children, but as well as to the families. Because we have that service in place it allows us to do early identification and intervention with the child as well as with the parents who are going into the housing developments, the projects, we are identifying substance abuse problems, we're identifying health needs and again it goes back to the coupling of primary health care and alcohol and drug abuse services.

Inclusive also within the Department of Addictions and Preventive Health Services we have an outpatient program. Our outpatient program provides services to those individuals that are referred to us from criminal justice systems, D.U.I. programs, Driving Under the Influence, as well as other various social groups in the community, families, friends, as well as volunteers. The most restrictive environment that we offer is a residential program for chemically dependent women. What we've done with that program is move to specialize in the treatment of chemically dependent women. We created a specialty in the sense in that we accept pregnant females.

An additional unique service that we offer is that we allow the mother to come in, pregnant, she can bring in two additional children up to the age of 5. We provide childcare services on site so the mother can come into our program, pregnant, deliver, maintain a child. Now I need to further explain what is listed here in your handout, but the program is a very structured program. It's what we call in the field a therapeutic community model. That model requires that the program is broken down into phases. We have five phases within this program which is orientation, freshman, sophomore, transitional, and aftercure. Reentry. The model has a token economy system which tends to feed into the drug abuser's needs to have immediate gratification.

Let me digress a little bit and say that anyone who comes into our service must go through a detoxification program. So that's one of the requirements, but additionally the graduation criteria for this program is that you must be gainfully employed for a minimum of 90 days, you must have an approved place to live, you must have a minimum of $500 in savings and if you come into our program without a high school diploma we offer on site G.E.D. classes. The reason why I've designed this program like this is because realizing the population that I was going to be working with it became important to me that we try to address some of the reasons people relapse and go back to drugs, such as the lack of education, lack of employment ability skills and all those kinds of services we provide inherent within treatment, what we've tried to do is normalize the need to intervene in the various subsystems.

So essentially we're trying to I guess correct some of the pitfalls or some of the safety nets that have eroded in society, so that's why we require that our patients go through the different steps within the program.

I need to also mention to you that our program is a long-term program. This program is 6 to 9 months in length so the ladies there are long term. I brought with me some newspaper clippings about the program because in our first year we felt we've been very successful. We've graduated seven ladies and given birth to three drug free babies and we know that some of the panel members, the committee members have stated earlier that you can find programs like this around the country. They tend not to treat large segments of individuals.

Our program is only a year and a half old. Within the last year we've been fighting zoning battles. We've been successful. We're planning to expand our model to 40. But I wanted to share that information with you all because we think we're successful. Being a systems person and having some government experience I think if I was to make a recommendation I would make the recommendation that your committee, Mr. Miller, review the coupling of primary health care services with alcohol/drug abuse and mental health services. I think that because of the design and goals of the primary health care system, which is aimed for the disadvantaged and which is usually in the inner city and in some rural areas, that population is the same population when we single out the crack cocaine users and if we could through systematic joint affiliation agreements or some type of agreement, because you're going to be joining two major systems, if we could facilitate that then I think that we could really do ourselves a service as far as trying to meet some of the needs we're experiencing with our crack cocaine addictions.

Chairman MILLER. Thank you. Thank you for coming up with a successful program to be overrun by members of Congress who want to look at it.

[Prepared statement of Toni Shamplain follows:]

PREPARED STATEMENT OF TONI SHAMPLAIN, DIRECTOR OF ADDICTIONS AND PREVENTIVE HEALTH SERVICES, FAMILY HEALTH CENTER, INC., MIAMI, FL

Good morning, my name is Toni Shamplain, I am the Director of Addictions and Preventive Health Services, Family Health Center, Inc., Miami, Florida.

It is an honor and pleasure to be invited to speak to you regarding such a timely issue as Cocaine and its effects on Women, especially, pregnant Women.

I have with me, Dr. Estelle Whitney, M.D., to assist with any medical questions that you may have. I have also included within my written testimony Dr. Whitney's views and statements.

I have been asked to share with you information regarding the services we, the Family Health Center, provide, as well as share our concerns regarding additional service needs and to discuss the impact of Crack-Cocaine on our patients.

The most current information received from the single state agency of florida, the Department of Health and Rehabilitative Services (HRS) reflects a total of 2.512 newborns have been identified as drug-exposed and/or suspected of drug exposure.

To further detail this information, the State of Florida is divided into eleven (11) Districts with State Health Department Units providing services. The information is as follows:

District One (1)	44

District	Two (2)	53
District	Three (3)	163
District	Four (4)	237
District	Five (5)	189
District	Six (6)	309
District	Seven (7)	97
District	Eight (8)	154
District	Nine (9)	376
District	Ten (10)	264
District	Eleven (11)	626
	TOTAL:	2,512

This information is for calendar year 1988. (received April 20, 1989)

INTRODUCTION

No one can deny that the effects of drugs on our communities are devastating. The crisis which is occurring in Washington, D.C., is mirrored in Metropolitan Dade County, and has impacted on all part of life. It is apparent through increases in violence, in crime, in sexaully transmitted diseases and AIDS, and in children who are born addicted and/or affected by these substances.

Health-care officials and authorities have not yet been able to find the answers to adequately deal with individuals, particularly pregnant women and their children, whose lives have been complicated through substance abuse. There is an urgent need for local, state, and federal funding of programs geared to educate and render medical services, as well as providing the option of removal from the influences of environment.

Drug abuse is one of the major crises of this period. However, what is most alarming is that the effects of the present crisis will continue to mushroom over the next several decades. Society, of course, will pay--in court costs, jails, rehabilitation facilities, medical services, and follow-up. But it will be the children--born addicted, with brains already damaged or destroyed, dying or sick with AIDS or other diseases--who will have to pay the ultimate price.

Dr. Estelle Whitney

THE EFFECTS OF PRENATAL DRUG ABUSE

MATERNAL:

- Poor Nutrition
- No Prenatal care
- Premature Rupture of Membranes
  (the bag of water is broken before the baby is ready to be born)
- Premature Labor
- Spontaneous Abortion
  (miscarriage)
- Placental Abruption
  (separation of the placenta from the wall of the uterus, leading to fetal brain damage and death)
  (separate from the wall of uterus)
- Hypertension
- Cardiac Arrhythmias
- Cerabral Vascular Ischemia
  (stroke)
- Seizures

FETAL:

- Death (stillborn, miscarriage)
- Low Birthweight
  (either due to prematurity or disorders of fetal growth)
- Small Head Circumference
  (related to decreased capacity for learning)

- Cerebal Hemorrhage

- Neurophysiologic & Neurobehavioral Abnormalities (dyslexia, hyperactivity, learning disability)

COMMUNITIES:

- Two (2) studies indicate that the classic drug-abuse gravida to be poor, unmarried, Blacks or Hispanics.
- Learning disabled children.
- Sick mothers and children require prolonged hospital stays and long-term follow up care.
- Children are exposed to drug using and seeking behavior.
- Increased transmission of STD's and AIDS.
- Scapegoat tactics by government prosecutors.
- Perpetuation of the "Cycle of Poverty".

WHAT CAN WE DO?

1. Pregnancy provides motivation to discontinue substance abuse.
2. Support increasing number of rehabilitative programs.
3. Stress the importance of prenatal care and good nutrition.

ECONOMIC OPPORTUNITY
FAMILY HEALTH CENTER, INC.
5361 N.W. 22nd AVENUE MIAMI, FLORIDA 33142 TELEPHONE (305) 637-6400

ECONOMIC OPPORTUNITY FAMILY HEALTH CENTER, INC.
5361 N.W. 22nd Avenue
Miami, Florida 33142

Marilyn J. Holifield
President, Board of Directors

Jessie Trice
Chief Executive Officer

TOTAL NUMBER OF USERS:	54,538 includes all users, i.e. Substance Abuse
TOTAL NUMBER OF MEDICAL VISITS:	120,685
TOTAL NUMBER OF VISITS:	251,566
NUMBER OF PROVIDERS:	27.5 8 Pediatricians 3 Internists 6 Family Practitioners 2 Ob-Gyns 4.25 Dentists 4 Physician Extenders (2 CNM; 1 PA; 1 ARNP) All physician providers with the exception of one (1) are Board Eligible or Board Certified.
NUMBER OF STAFF:	234
AMOUNT OF OPERATING BUDGET:	$8,461,796
HOURS OF SERVICE:	Main Facility Monday - Thursday 8AM - 9PM Friday 8AM - 5PM Saturday 8AM - 12 Noon All Other Facilities Monday - Friday 8AM - 5PM

ECONOMIC OPPORTUNITY FAMILY HEALTH CENTER, INC.

THE EVOLUTION OF THE SUBSTANCE ABUSE PROGRAM

During the mid-70's, Family Health Center requested funds from the Dade County Mental Health Board of Directors to operate an outpatient alcohol program. This request emanated from concerns of the clinical staff regarding the alcohol consumption, the diagnosis of patients served by the Center and the poor follow-through of patients referred to alcohol programs.

The Mental Health Board of Directors provided $75,000 for alcohol counselling, predicated upon by Family Health Center, Inc., agreeing that it would accept court referrals.

This program remained as was except for an increase in the numbers of alcoholics until 1981 when it was found that most alcoholics abused other drugs as well. Attempts were made to identify the drug of choice (alcohol mostly, or illegal drugs primarily) and refers those whose choice was an illegal substance to other programs. This separating of patients' treatment did not work for several reasons. Firstly, there was a scarcity of programs available accepting referrals, secondly, many patients never made the effort to follow-through and thirdly, those that did, rarely completed the program.

As the illegal drug problem worsened, our patient population was more impacted. We requested funding from the Mental Health Board of Directors to treat poly-drug users. They welcomed our request as they recognized our patients as difficult to work with,(poor, Black, many times homeless with criminal records, and predominately male). Our budget increased from $150,000 to $240,000.

The early '80's brought on an epidemic of heroin i.v. drug users, all sorts of pill abusers, especially valium, and marijuana galore. Rarely did we have a cocaine addict. Our success on an outpatient basis with this population was very poor, except for those who had been detoxed and completed a residential program. Must of the illegal drug abusers were men, 18-35 years of age, who had some involvement with the criminal justice system. Less than 5% of the patients were female.

The dropout and recidivism rates for Black males in residential programs were excessively high, 80-90%. State Senator Carrie Meek obtained funding for an independent study to determine why these programs were not effective for Liberty City residents. Her study revealed that inner city residents had great difficulty establishing rapport, believing staff were interested in them and in communication.

It was during this time that the one inner city and several other residential programs closed down because of funding reductions. We however, continued to try and get people admitted to these program as we knew our chances of success on the outpatient level was a bit better if the patient had spent some time in a residential program. Therefore, for those we were able to get admitted, we kept close ties with the program so as to pick up the client as soon as he left the residential program.

We believe that the physical health care provided was a great incentive for several patients to remain sober. They learned about their disease (high blood pressure, heart condition, anemia, poor teeth, etc.) and how drugs cause or contribute to these health problems. Self-esteem seemed to increase.

As early as 1984, we recognized the need to have more accessible, available and culturally sensitive residential programs.

It was during this time that we began to see more designer drug use and cocaine free-basers.

Sexually transmitted diseases among prenatal patients sky-rocketed -- investigation revealed that sex was exchanged for cocaine free base. Seeing this venereal disease epidemic in many of our patients was a new phenomena. Whereas we had always had some venereal disease in our maternity population, we'd never seen anything like this explosion.

As soon as "crack cocaine" entered, not only did we have sexually transmitted diseases, we had a whole set of new problems.

We'd already found that no residential program would accept pregnant women. We further found that most non-pregnant women with children had severe problems as well. To get on a waiting list meant finding someone to keep the children while the womam was in the residential program. Many women had no one to turn to, and had to decide between giving up their children to State Foster Homes to gain eventual admission to a residential program, or keeping their children and struggling with a drug that controlled them. Most opted for the latter.

Our county hospital began testing newborns and found an alarming number being born addicted to cocaine -- most came from our area.

We finally had to conclude that it made very little sense to have Board Certified Obstetricians providing prenatal care to "stoned" women who cared about nothing but their next "hit". Further, the State Health Agency had begun to discuss follow-up of women post delivery, because so many of these women were abandoning these addicted babies to the hospital.

Whereas this may be a necessary step, it seemed to us that preventing the baby's addiction made more sense. Plus, pregnant women are more receptive to care if they don't have to choose between treatment and giving up their children.

Staff presented findings and concerns to the Board of Directors. Our Board identified a State Legislator to champion our cause. Staff began to work with the State Substance Abuse Agency.

A theraputic program for women with emphasis on pregnancy was developed. National Health Serve Corps (NHSC) Obstetrician, Dr. Estelle Whitney, developed the protocals and eagerly volunteered to personally provide prenatal services, deliver all of these women and provide postnatal care.

A group home for children up to age 5 was included as an important part of the program.

Having learned a lot about "crack cocaine", our program was designed to be 6 months to 12 months in length, depending on the person. Upon completion, patients are followed in outpatient for a minimum of 6 months after which they will have identified an AA or NA sponsor who will submit monthly reports for one year and quarterly reports thereafter. Counsellors will visit at least quarterly after outpatient is completed until the end of a five-year period.

During the 1987 State Legislative Session, we were awarded $500,000 as start-up, facility acquisition and treatment funding.

During 1983, State Senator Carrie Meek asked us to develop a school-based program that would prevent substance abuse. We had visited an ALPHA (A Learning Place for High Achievers) Program in another part of the State, so we presented this program to Senator Meek. She obtained State funding for one elementary school and assisted us in securing the additional funding from the local public school administration. In fact, the program costed $135,000, of which the school system provided $80,000, mostly inkind services.

ALPHA focuses on children ages 8-12 years who are capable, but are not performing academically up to their grade level, and who exhibit negative behavior.

These children are assigned gifted teachers, with not more than 15 children per teacher. A counselor works individually with the child and his family. In fact, parents or guardians must sign a contract agreeing to work with the counsellor to implement the plan developed for each child. So the counsellor makes home visits as well as schedule and follow-through on group sessions. Positive change in behavior is rewarded by a point system.

Many of these children live with parents on drugs or are they latch-key children in drug infested areas. Others live with relatives in overcrowded unsanitary housing and some live from place to place with relatives or neighbors. All of these children are of average or above intelligence and are capable of succeeding.

ALPHA accepts children twice in a school year. So during one school year, 60 children go through the ALPHA Program.

The school system provides the space, teachers and teachers' aides. All school supplies, other school specialists such as psychologists, etc., pre and post testing materials and office furniture.

We provide a counselling manager, counsellor, clerical person, telephone and mileage for staff. During the summer, home follow-up is intensive for all graduates as children are followed for 5 years or until high school graduation, whichever comes first.

Several children have won academic awards and sports awards. Seventy-three percent (73%) of the children continue to perform well.

Extreme care is taken to avoid ALPHA children feeling that they are in our program because they are" bad".

We now have two (2) ALPHA elementary schools, and have been requested to add two (2) more.

Vice-President Quayle visited one of the schools earlier this year.

Since 1974, we have increased our substance abuse budget from $75,000.00 to $1,288,605.00. Simultaneously, we have increased our services from outpatient for 30 alcoholics to 300 poly-substance abusers, a residential program for pregnant women and non-pregnant women (15), a group home for children of those women - 5 years and under, two (2) elementary school-based substance abuse prevention programs and an AIDS outreach program.

By the end of 1989, we will have expanded our residential program to 40 women and 15 men. We are in the process of purchasing a 12,000 square foot residential facility and we are negotiating with the County for an additional 40-bed facility.

The route we have taken may not be necessary for other community health Centers, but we have learned that without the provision of substance abuse services, the provision of primary health care is wasted and negated.
We further believe that substance abuse services should be integrated into primary

care because all substance abusers have severe health problems - to treat one and not the other is a waste of resources. In our humble opinion, it is efficient and effective to treat the whole person and not the parts.

ECONOMIC OPPORTUNITY FAMILY HEALTH CENTER, INC.

RESIDENTIAL TREATMENT COMPONENT
(WOMEN ONLY)

THE RESIDENTIAL PROGRAM COMPONENT IS GEARED TOWARD SERVICE FOR WOMEN, AGES 18-34. WE PROVIDE A THERAPEUTIC ENVIRONMENT WITH A CAPACITY FOR 15 CLIENTS. THE PROGRAM OPERATES 24 HOURS A DAY, SEVEN DAYS A WEEK, AND IS STRUCTURED IN FIVE PROGRESSIVE PHASES:

1. ORIENTATION
2. FRESHMAN
3. SOPHOMORE
4. TRANSITION
5. AFTERCARE

THESE SERVICES INCLUDE:

1. SELF-HELP
2. THERAPEUTIC TREATMENT PROCESS WHICH FOCUSES ON INDIVIDUAL PROBLEMS
3. RE-ENFORCES AND REWARDS RESPONSIBLE BEHAVIORS
4. ENCOURAGES PERSONAL INDEPENDENCES

CONTACT PERSON:

Eric Jones, Intake Specialist
FAMILY HEALTH CENTER, INC.
5361 N.W. 22ND AVENUE
MIAMI, FLORIDA 33142
(305) 637-6483

RESIDENTIAL PROGRAM GOALS AND OBJECTIVES:

The overall goal of this program is to provide a comprehensive system for the rehabilitation of the chemically-dependent person. The services provided enable the clients to work toward a productive lifestyle; economically, socially, psychologically and physically.

OBJECTIVES:

1. To aid the clients in establishing independent living skills.

2. To ensure that clients are drug/alcohol free through Family Health Center's laboratory testing on a random basis.

3. To aid the client in refraining from criminal activity by linkages with the TASC Program, Probation and Parole, and Department of Corrections.

4. To ensure that all capable clients obtain a G.E.D. Certificate.

5. To provide an opportunity for clients to obtain employability skills through appropriate linkages with other agencies.

RESIDENTIAL PROGRAM GOALS AND OBJECTIVES:

OBJECTIVES (continued)

6. To aid clients in the development and maintenance of good health by active participation in daily recreation and social network programs.

7. To involve the client in Narcotics/Alcoholics Anonymous meetings to be conducted during and after completion of treatment.

8. To ensure that clients demonstrate the ability to develop and maintain positive interpersonal relationships by becoming involved in community service work and participating in Residential Women Peer Groups, etc.

9. To re-establish relationships with family members and significant others via family therapy and social network activities.

10. To ensure client awareness of harmful effects of drugs on the body utilizing drug education modules and other information.

11. To assist clients in gaining necessary coping skills by conducting communication skill groups, assertiveness training groups, stress reduction, problem solving, relaxation groups, etc.

12. To provide an opportunity for the client to gain self-worth and higher self-esteem through community education.

13. To ensure that the clients strive to reach short and long terms goals, Personalized Treatment Plans are developed by clients and the Primary Therapist.

14. To reunite clients into a family unit.

15. To provide Primary Health Care Services.

AIDS OUTREACH/EDUCATION

FAMILY HEALTH CENTER CONTINUES TO SEEK OUT WAYS AND MEANS OF SAFEGUARDING THE HEALTH OF LOCAL COMMUNITY RESIDENTS. FUNDS RECEIVED FROM THE STATE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES HAVE ENABLED THE AGENCY TO PROVIDE INFORMATION AND EDUCATION ON AIDS PREVENTION AND RISK REDUCTION.

THESE SERVICES INCLUDE:

1. INDIVIDUAL AND GROUP DISCUSSIONS WITH AT-RISK PERSONS.
2. DISSEMINATION OF PRINTED MATERIAL.
3. COUNSELING.
4. REFERRALS FOR HIV TESTING AND OTHER RELATED SERVICES.
5. REFERRALS FOR SOCIAL AND ECONOMIC SERVICES.

IT IS OUT HOPE THAT EVERYONE WITHIN OUR CATCHMENT AREA WILL HAVE A BETTER UNDERSTANDING OF THIS DISEASE, AND TAKE ALL NECESSARY ACTIONS TO PREVENT ITS FURTHER SPREAD.

CONTACT PERSON:

MS. CHERYL WHEELER, COORDINATOR
DEPARTMENT OF ADDICTIONS AND PREVENTIVE
HEALTH SERVICES
5361 N.W. 22ND AVENUE
MIAMI, FLORIDA 33142
(305) 637-6483

OUTPATIENT COMPONENT

THE OUTPATIENT COMPONENT PROVIDES ADDICTION AND PREVENTIVE HEALTH SERVICES TO INDIVDUALS AGES 18 AND OVER THAT RESIDE WITHIN THE LIBERTY CITY AND METRO-DADE COUNTY CATCHMENT AREA.

THESE SERVICES INCLUDE:

1. OUTREACH
2. ASSESSMENT EVALUATION
3. CASE MANAGEMENT
4. EDUCATION/INFORMATION
5. INDIVIDUAL/GROUP THERAPY
6. FAMILY/COUPLE THERAPY

CONTACT PERSON:

MR. WILLIAM PRATT, SUPERVISOR
FAMILY HEALTH CENTER, INC.
5361 N.W. 22ND AVENUE
MIAMI, FLORIDA 33142
(305) 637-6483

SERVICE HOURS:

MONDAY THRU THURSDAY 8:00AM - 9:00PM
FRIDAY 8:00AM - 5:00PM

ALPHA COMPONENT

THE ALPHA COMPONENT PROVIDES SPECIALIZED SERVICES WHICH DEALS WITH ELEMENTARY CHILDREN IN GRADES 3-6 WITH VARIOUS PROBLEMS.

THESE SERVICES INCLUDE:

1. BEHAVIORAL MODIFICATION
2. FAMILY INTERVENTION
3. CLASSROOM MANAGEMENT
4. GROUP COUNSELING

THERE ARE TWO LOCATIONS:

CHARLES R. DREW ELEMENTARY SCHOOL
1700 N.W. 60TH STREET
MIAMI, FLORIDA 33142

HOLMES ELEMENTARY SCHOOL
1175 N.W. 68TH STREET
MIAMI, FLORIDA 33147

CONTACT PERSON: ROVAN G. LOCKE, PH.D. (305) 836-0800

SERVICES HOURS ARE MONDAY THRU FRIDAY 8:00AM - 5:00PM

ECONOMIC OPPORTUNITY
FAMILY HEALTH CENTER, INC.
5361 N.W. 22nd AVENUE MIAMI, FLORIDA 33142 TELEPHONE (305) 637-6400

OVERVIEW OF THE

RESIDENTIAL SUBSTANCE ABUSE SERVICES FOR WOMEN

Family Health Center, Inc. provides Primary Health Care Services to more than 50,000 Liberty City residents annually. In the past two (2) years we have seen "Crack Cocaine" become a full blown epidemic. It has made elementary school children become criminals and enslaved. Adolescents and adults are giving birth to addicted infants. Babies are being left in garbage disposals to die. Children are being left alone in greater numbers. An increasing number of residents are losing the jobs that only a few were able to find. Sexually transmitted diseases, which have always been rampant, are now an ever escalating epidemic complicated by a growing AIDS population. In fact, we believe that 1 of every 4 adults enrolled with us abuses drugs, mostly "Crack Cocaine" and alcohol.

Family Health Center, Inc. began treatment of addicted persons in 1974. At that time, the focus was on alcoholism. A small grant from the Dade-Monroe Mental Health Board enabled the agency to employ staff. The program grew because of the need, the location and because it was a part of a larger health care facility.

During the latter part of 1979, it became evident that most clients abused alcohol and other drugs. Additional funding was obtained to treat poly-abusers.

The mid 1980s brought on the "Crack" epidemic. We began to see more and more pregnant women abusing this drug and our effort to obtain drug treatment for them yielded very poor results. As a health care provider, we understood that our high quality prenatal care was useless if the mother continued her addiction.

Additionally, the medical staff at the University of Miami - Jackson Memorial Hospital, that delivers the babies of the women from Family Health Center, interviewed mothers after delivery. They found a large number of mothers were "Crack Cocaine" users during pregnancy. Many infants were born addicted and several were abandoned at the hospital. These abandoned babies created a financial crisis for the hospital as the State did not have sufficient foster homes to accept them.

Experience has taught us that it is virtually impossbile for "Crack Cocaine" users to remain drug free in an outpatient setting. We have also found that the short term 28-30 day residential programs rarely result in continuing sobriety for this population.

Further, we have learned that very important to the success of any substance abuse treatment is the treatment of physical health problems.

Practically all drug/alcohol abusers are in very poor physical health. It is a waste of time and funds to attempt drug/alcohol treatment and neglect the physical health problems. It is next to impossible to feel good about one's self, get a job and become a societal contributor if one has heart disease, hypertension, poor teeth, inadequate nutrition, anemia, etc. We strongly believe that successful rehabilitation of an addict hinges on a program that treats the total person and his family.

Dade County has many substance abuse residential programs. However, these programs are not accessible nor available to the majority of Family Health Center, Inc.'s population. Our population consists of many poor, unemployed and homeless persons. Many of these people have various health problems. Several programs cost $8,000 - $15,000 for a 28-30 day stay. Those programs that do accept our patients all have long waiting lists. To tell an alcohol/drug addict he has to wait from two (2) to four (4) weeks to get into a program is comparable to telling a drowning man he will be rescued within an hour.

Obtaining a residential bed for women is even more problematic. Not only is there is a long waiting list, but most women addicts/alcoholics have small children. Their fear of loosing their children to the State System is as much a deterrent to sobriety and rehabilitation as the scarcity of beds. They become much more receptive when the custody and care of children remains with them.

Armed with the knowledge that residential services and rehabilitation for pregnant and non-pregnant poor mothers were almost nonexistant; that more and more babies born to poor women were born addicted; that many of these babies were abandoned to eventually become wards of the State and that serveral were severely abused, we, through our Board of Directors began to work with local and State leaders for funding in 1986.

The Florida State Legislature appropriated $500,000 of a $1.2 million request, in 1987, to fund a pregnant/non-pregnant residential program for poor women. An important part of the total program was a group home on or near the residential facility's premises for children of the women. In addition to staffing the home with caring, qualified staff, the children were to have psychological testing and counselling as needed, health care and close contact with the parent to establish bonding and ensure that both mother and children develop good emotional and physical health habits.

Unfortunately, enough funding was not provided to implement both components simultaneously. However, the Commission of the City of Miami did award $30,000 to defray the cost of some of the psychological testing and counselling. Family members and friends were identified to to provide shelter and child care services.

Some of these situations were less than ideal, but at least the children did not become wards of the State. Funds were budgeted to keep all newborns in the residential facility.

Due to community outrage over escalating drug abuse, fear and crime, the zoning changes needed to lease or purchase a facility were impossible to obtain. However, in mid-November, 1987, to avoid delay in accepting patients, temporary arrangements were made. An apartment complex was rented for housing; a van was purchased for transportation; space was rented for counselling from the local Urban League,etc.; and the first seven (7) women (three (3) pregnant) were admitted.

The funds received in 1987 were awarded through the State Department of of Health and Rehabilitative Services. These funds were a part of the federal dollars issued to the State on a yearly basis. During 1988, we requested additional funding for children services, detoxification, and services to men. These funds were requested from the State's General Revenue Fund to ensure continued funding. We did not receive funding for detoxification, but we did receive $125,000 for men, $225,00 for children and $500,000 for women, all from the recurring General Revenue Fund.

Denial of the request for detoxification funding may reduce our capacity to accept pregnant women somewhat. As is commonly known, most pregnant addicts are high risk, therefore detoxification must be managed in a hospital setting with very close follow-up thereafter by an obstetrician. Detoxification of pregnant women may take as long as 30 days depending on the woman's conditions. Dade County does not have a hospital that affords such care for poor women. There is a County Detox Center, but in addition to a waiting list, it will keep patients only up to seven (7) days. However, we have been fortunate enough to make arrangements with two private hospitals that will accept our pregnant women for as long as necessary - in return, we accept some of their clients in our outpatient program when funds are depleted.

The Residential Substance Abuse Component for Women is one of five (5) comprising the Department of Addictions and Preventive Health Services. The other 4 components are:

1. Outpatient Substance Abuse
2. ALPHA - "A Learning Place for High Achievers". This is an elementary school dropout preventive program.
3. AIDS:
    a. Community outreach that focuses on drug addicts, prostitutes and other high risk persons;

b. Counselling pre and post-test as well as on-going counselling.

4. Health Education

The Residential Substance Abuse Component for Women accepts detoxed women 18-35 years of age and women in the first trimester or the beginning of the second trimester of pregnancy. Major objectives are to:

1. Provide a climate that results in lifestyle changes from one of alcohol/chemical dependency, to one of productivity in a responsible manner
2. Prevent the birth of alcohol/chemically dependent infants

To accomplish the objectives, the following is provided:

1. A 7-day, 24-hour drug/alcohol free and therapeutic environment
2. Adequate, appropriate and qualified 7-day, 24-hour staff
3. Comprehensive Primary Health Care including Dental Services
4. Infant Care on the premises by qualified staff, 12 hours a day, 5 days a week
5. Individual treatment plan
6. Individual and group counselling and therapy
7. Parenting education
8. Close contact with children and other family members
9. High School Equivalency (GED) Preparation
10. Job training and placement
11. Support groups - AA/NA
12. Aftercare and long-term follow-up

The length of stay depends upon the individual. The range is 6 months to 12 months with 9 months being the average. Almost 100% of the residents are addicted to "Crack Cocaine", however, several abuse alcohol and other drugs. Needless to say, thus far, "Crack Cocaine" is the most difficult drug for addicts to relinquish.

This program consists of 4 phases, each with specific client responsibilities and client priviledges. Rules and disciplinary actions including termination are clearly delineated.

Source of Referrals

Family Health Center, Inc.'s Patient Population
Outpatient Substance Abuse Program
Individuals' Families/Friends
Criminal Justice System
Public School System
Metro-Dade County

SUMMARY

The Residential Services have been operative for one (1) year November, 1988, with a capacity to treat fifteen (15) women.

Statistics for one year - November 1987 to November 1988

Admissions	26
Pregnant	6
Non-pregnant	20
Deliveries	3 - Full-term, normal birth weight and drug-free
Graduates	7
Dropouts	6 - Non-pregnant

Requirements for Graduation:

1. Minimum of 6 months sobriety
2. General Education Diploma if client is capable but is not a high school graduate
3. Decent affordable housing
4. 90 days of employment
5. Bank account with a minimum of $500.00
6. Regular attendance at Alcoholics/Narcotics Anonymous meetings
7. Alcoholics/Narcotics Anonymous Sponsor
8. Enrollment in Aftercare

The First Graduating Class was comprised of the original seven (7) enrolled. The three (3) who were pregnant delivered healthy babies.

Their work status is as follows:

AIDS Peer Counselor	Family Health Center, Inc.
Service Attendent	Southern Bell

Work status (continued):

Medical Assistant	Andersen Health Center
Sales	The Miami Herald
Clerk Typist	Metro Dade County
Manager	Jessica Cookies/Omni
Housemother	

Although these seven (7) women have completed the intensive residential program, they have not been discharged. They are enrolled in the outpatient or aftercare program where individual and group sessions are regularly scheduled on a weekly basis. Additionally, they attend AA or NA meetings at least once a week. Each has an AA or NA sponsor. Additionally, the graduates have organized into a support group for themselves.

Upon completion of the outpatient program, which may be as little as 6 months, or as long as 18 months, follow-up and evaluation will continue for a total of five (5) years from the date of admission to the residential program. We plan to accomplish this through monthly reports from AA/NA sponsors, periodic outreach (home visits) and involvement of the graduates as role models to those in the residential program.

Whereas we do not know what our success rate will be, we strongly believe that we have developed a model that should be closely observed by others for replication. We do know that we have the only Residential Substance Abuse Program in the State of Florida that accepts pregnant women.

Funding to lease or purchase a building has been approved by the Florida State Department of Health and Rehabilitative Services, but efforts to obtain the necessary zoning changes three times on three buildings at different locations have been defeated. A fourth building has been identified and staff is working with the homeowner's association and businesses to improve understanding and minimize opposition to the required zoning changes.

We are cautiously optimistic that a move from the temporary quarters to a permanent facility will occur in the very near future.

Should questions regarding cost arise, the following information should be considered:

1. Start-up costs are usually higher for any new program
2. The accommodation of fifteen (15) clients as a maximum relates to the space available. A permanent facility will allow a

minimum of 40.

3. The cost of hospitalizing three (3) addicted infants probably would have exceeded the total amount spent on this program.
4. Foster home care for these infants could very well have been an outcome. Such costs must be considered.
5. As many as ½ of the women probably would have been incarcerated. These costs as well as the crimes that would have been committed are very important considerations.

More important than any of the above, is the fact that reuniting families, relieving human suffering and improving self esteem is worth more than any sum of money.

Chairman **Miller**. Ms. Cole.

STATEMENT OF CAROL COLE, M.A., CHILD DEVELOPMENT SPECIALIST/TEACHER, SALVIN SPECIAL EDUCATION CENTER, LOS ANGELES UNIFIED SCHOOL DISTRICT, LOS ANGELES, CA

Ms. **Cole**. Representative Miller, I would like to thank you, members and staff of the committee for inviting me to provide testimony. My name is Carol Cole and I am a Child Development Specialist/Teacher working for Los Angeles Unified School District. The past two years I have been teaching in a pilot program for children who have been identified as prenatally exposed to drugs, ages three to six years old. The purpose of the program is to provide services to preschool children who are quite competent cognitively but who are defined as high risk because of the prenatal exposure to drugs.

We provide an enriched, supportive environment where children can learn to believe in themselves, trust adults, modulate their own behavior and interact cooperatively with peers.

We hope that if children learn these skills they will succeed in school and later in life. The strategies that we employ can be taught to and implemented by the many adults who interact with these children. The mechanism crucial to the development and evolution of the program is a weekly transdisciplinary team meeting to coordinate, consult, plan and evaluate.

Let me share with you if I might some scenes in my classroom.

In the sandbox, Lonnie and Timmy are cooking. Lonnie gets upset, reaches into her sock, pulls out a pretend knife and wields it into Timmy's face.

Marta gets off the school bus and her reply to my good morning is a barking "Leave me alone. I don't want to talk to you." Later, she bumps into the wall, spills her milk and seems to have forgotten how to do the puzzle that she knew how to do well yesterday. On occasion she stares vaguely into space.

Timmy announces at sharing time, "I have a skateboard." Robin says, "Well, where is it?" Timmy begins to look increasingly puzzled and perplexed. So I go over to him. As a teacher I begin to ask him about the various houses in which he spends time each week. "Is it at Nancy's house?" This is his new foster mother. No. "Is it at Grandma's House? This is his new foster mother's mother. No. "Is it at Mrs. Lane's house?" This is his old foster mother. No. "Is it at Susan's house?" This is his biological mother's house. No. "Is it at Grandmother's house? This is his biological mother's mother's house. Yes, that's where the skateboard is.

Reading a favorite book, The Hungry Caterpillar to my class I asked if they could remember the special name of that special house that caterpillars make before they become beautiful butterflies. You could see them thinking. With a little prompting from me it starts Ca, Ca, Ca. Allen blurts out with enthusiasm, "cocaine!"

These children are three and four years old. And while the moments I described to you are very atypical for three and four year olds, children in my program do have many typical moments. Not surprisingly we are recognizing that these children are as impacted by their environments as by the prenatal exposure to drugs. After

8 months in school, Allen is now only beginning to talk about his mother's recent release from jail and how he does not want to go back to the monster house where he was left alone for days at a time and where they were always fussing.

Lonnie is being raised by her father. He is 50 years old and started using heroin at age 13 in Harlem. He feels that he has beaten the system just to be alive. Lonnie's 26 year old mother, as Lonnie will tell you, has to go to meetings because she uses drugs. Lonnie's grandmother died of AIDS contracted from her I.V. drug using husband. Lonnie's grandfather died of a heroin overdose.

As I described earlier Marta is showing signs of neurologic involvement. However, she is living with caring and concerned grandparents.

These simple descriptions allow you to see why we talk about the interaction between environment and prenatal exposure to drugs and why we say that there's no typical profile of the drug-exposed child. While these children are certainly more similar than dissimilar to their peers, most of them do show episodes of disorganization and behavioral unpredictability. In addition, they may display indiscriminate attachment, by that I mean going up to anybody at any time, or extreme fear and suspicion.

Early responsive care is crucial for children's emotional and cognitive well being. We know that only in the context of a good attachment will a child's true potential be known. As infants, these children are temperamentally very difficult. They may be placed where caregivers are untrained and overburdened. For example, 66 percent of our parents are over 50 years of age. Multiple placements often result. Fifty percent of the children in our program live in foster care or group homes. Seventy-five percent have had more than one placement and of these children the average number of placements is 3.1 each.

Carter was prenatally exposed to PCP, heroin and cocaine. He was removed from his mother at two years of age when authorities were investigating his sister's birth. She was born addicted and grossly deformed. A one year old brother was also removed. In a system designed to provide protection, Carter by age 3 and a half has been in six different places and currently lives in a group home where he has nine different caregivers.

Intervention strategies to be effective must attempt to counterbalance prenatal and perinatal risk factors and stressful life events. To accomplish this the teacher must build in protective factors within the classroom and provide facilitative ways for young children to appropriately cope with stress. We know what those protective and facilitative factors are.

Establishing a strong attachment with each child through understanding, acceptance and advocacy must be the teacher and the caregiver's major priority. When early intervention services are provided to drug exposed children and their caregivers positive developmental outcomes are enhanced. To successful work with this population as Drs. Halfon and Chavkin said so clearly this morning, interagency cooperation and coordination is vital.

Families must be involved. In addition, to successfully interact with children, specialized teaching and caregiving strategies are needed. These strategies are teachable. Serving young drug-exposed children in regular day care, preschool and kindergartens without specialized help will not be sufficient to meet their needs. Conversely, isolating these children into specialized classrooms is programmatically and economically unfeasible.

I would like to conclude these remarks by highlighting five areas of service delivery that need increased attention and development. First, programs that teach parents about the impact of drug abuse on the developing fetus are critical. Second, increasing the prenatal care available to mothers who are abusing or have abused drugs is essential. Third, additional drug treatment programs for pregnant addicts are needed.

Two additional areas of needed development relate to training of service providers or caregivers who are raising these children. First, support services for extended family members who take on the responsibility of these children must be increased. Currently, 30 percent of our children are living with extended family members. Respite care, day care and parent training are just a few areas in which extended families do need help. Second, we must provide training to day care, Head Start and school personnel so that these children can function successfully within their programs.

I hope my testimony has been helpful to the committee. I want to thank you again for providing me this opportunity to share children and families in our program with you. Ultimately the development of these children rests on what we as a society are willing to invest in longitudinal services for them and their caregivers.

Thank you.

Chairman MILLER. Thank you.

[Prepared statement of Carol Cole follows:]

PREPARED STATEMENT OF CAROL COLE, M.A., CHILD DEVELOPMENT SPECIALIST/TEACHER, SALVIN SPECIAL EDUCATION CENTER, LOS ANGELES UNIFIED SCHOOL DISTRICT, LOS ANGELES, CA

Representative Miller I would like to thank you, members and staff of the committee for inviting me to provide testimony. My name is Carol Cole. I am a Child Development Specialist/Teacher working for Los Angeles Unified School District. I have been working with high risk young children and their families for twenty years, the last ten with the Los Angeles Unified School District. This past two years I have been teaching in a pilot program for children who have been prenatally exposed to drugs, ages three to six.

I, as a classroom teacher do appreciate the opportunity to address this important issue.

In the sandbox, Lonnie and Timmy are "cooking." Lonnie gets upset, reaches into her sock, pulls out a pretend knife and wields it into Timmy's face.

Marta gets off the school bus and her reply to my good morning is a barking "Leave me alone. I don't want to talk to you." Later, she bumps into the wall, spills her milk at lunch and seems to have forgotten how to complete the puzzle she did well yesterday. On occasion she stares off blankly into space.

Walking down the hall one of the children, who has just started to trust me, says, "I don't want to hold your hand." I respond, "Okay, you don't need to," and I let go of his hand. He throws himself on the floor and starts screaming. After much searching for the answer to this puzzling interaction, I figure out what he really wants is for me to pick him up. He doesn't know how to ask for this.

Outside, children get into a dispute over who gets the next turn in the wagon. Jerry turns to Marta, says "shut up," and throws a Crip sign. The Crips, as I am sure you know is a Los Angels Gang involved in drug trafficking.

Timmy announces at sharing time, "I have a skateboard." Robin says, "Well where is it?" Timmy looks increasingly puzzled and distressed. As a teacher, I begin to ask him about the various houses in which he spends time each week. "Is it at Nancy's house (his new foster mother)?" "No." Is it at Grandma's house (his new foster mother)?" "No." "Is it at Mrs. Lane's house (his old foster mother)?" "No." It is at Susan's house (his biological mother's house)?" "No." It is at Grandmother's house (his biological mother's house)?" "Yes."

Reading a favorite book, The Hungry Caterpillar to my class, I asked if they could remember the special name of that special house that caterpillars make before they become beautiful butterflies. You could see them thinking. With a little prompting from me, "It starts, CA-CA-CA-," Allen blurts out with enthusiasm, "Cocaine."

These children are only 3 & 4 years old. While the moments I described are very atypical for 3 & 4 year olds, these children have many moments where they are very typical. We provide early intervention with the hope that we can increase the number of typical moments.

With interest from the Division of Special Education, Psychological Services, Health Services, and School Mental Health, Los Angeles Unified School District began a pilot program for preschool children prenatally exposed to drugs in the spring of 1987.

The purpose of the program is to provide services to preschool age children who are quite competent cognitively, but defined as high risk because of prenatal exposure to drugs.

Through an enriched preschool experience, home school interaction and interagency cooperation, we are developing strategies designed to help these children believe in themselves, and also abide by the larger society's rules. These strategies can be taught to and implemented by the many adults who will interact with these children.

We have attempted to provide a supportive environment where the children can learn to trust adults, to modulate their own behavior, to interact cooperatively with peers and to believe in themselves. We hope that if children learn these skills, they will succeed in school and later on in life.

The pilot now consists of three classrooms for children, two are located at the Salvin Special Education Center and are for children three to five years of age. The third classroom is at Seventy-Fifth Street School and is for kindergarten age students, and has for one of it's purposes mainstreaming--placement in regular classrooms. Each classroom consists of three adults to a maximum of eight students. A psychologist, social worker, nurse and pediatrician are assigned to work part time with children and families. The children also receive the services of an adaptive physical educator and a speech and language therapist as needed.

Key components of the program include:

- developing a referral network with hospitals, social service agencies and foster care providers;
- screening students to determine appropriateness for the program, including psychological and medical evaluations;
- establishing a working partnership with the parents or guardians, including home visits, school conferences, parent education and coordination of support services;
- classroom intervention for the children to further assess needs and provide positive and integrated learning experiences in social, emotional, motor, speech and cognitive areas;
- monitoring progress to determine readiness for transition to alternative placements;
- evaluating students and the program to provide information to the School District for policy making and to the school staffs for providing ongoing services to this population

The mechanism crucial to the development and evolution of this program was a weekly transdisciplinary team meeting to coordinate consults, plan, share and evaluate.

FINDINGS:

1. Not surprisingly, we are recognizing that these children are as impacted by their environments as by the prenatal exposure to drugs. After eight months in school, Allen is only now beginning to talk about his mother's recent release from jail and how he doesn't want to go back to the "monster house" where she left him alone for days at a time and where "they was always fussin." Carter was prenatally exposed to PCP, heroin and cocaine. He was removed from his mother at

2 years of age when authorities were investigating his sisters birth. She was born addicted and grossly deformed. A one year old brother was also removed. In a system designed to provide protection, Carter by age 3 1/2 has been in six different placements and currently lives in a group home where he has nine different caregivers.

Lonnie is being raised by her father. He is 50 years old and started using heroin at age 13 in Harlem. He feels he has beaten the odds to even be alive. Lonnie's 26 year old mother, as Lonnie will tell you, has to go to meetings because she uses drugs. Lonnie's grandmother died of AIDS, contracted from her IV using husband. Lonnie's grandfather died of a heroin overdose.

Jerry was recently kidnapped by his mother when she lost custody of him due to alleged reuse of drugs.

As I described earlier, Marta is showing signs of neurological involvement. She is living with caring, involved grandparents. I've already told you about Timmy's five biological and foster home situations. I also want you to know that he is caring, and interested in learning and very rescueable. These simple descriptions allow you to see why we talk about the interaction between environment and prenatal exposure to drugs; and why we say that there is no typical profile for a drug exposed child.

2. These children display a broad range of problems from severe handicapping conditions to risk factors. They present a perplexing, often times difficult-to-articulate-in-specific terms set of behaviors that are not acceptable in classrooms. Exaggerated behavioral patterns are often a way a child copes with a situation that is overwhelming to him/her. These behaviors may continue in more aggravated forms unless the child receives intervention services.

   These vulnerable children may display poor motor skills, delays in speech and language, poor problem solving, attention and concentration difficulties, inability to organize play and extremes in behavior ranging from apathy to aggression, from passivity to hyperactivity, from indiscriminate trust to extreme fear and suspicion.

   The problem is further complicated because these behaviors often present themselves intermittently. Sometimes one can identify something into the environment that seems to cause the behavioral difficulty; other times a special event cannot be identified. This unpredictable pattern makes it difficult for caregivers, be they teachers or parents, to accurately read children cues. Most of the children in the pilot program show episodes of disorganization, behavioral unpredictability and difficulties with attachment. In a sense the cognitive competence demonstrated by this group will not be enough, by itself to protect them against school failure.

3. In early infancy, these children are noted to be difficult to handle, comfort and feed. They are described as jittery, irritable and unable to organize their responses to sights,

sounds, objects and people in the environment. These behaviors make the formation of a strong attachment between caregiver and child less likely than with a typical child.

There are also factors on the caregiver side which may interfere with attachment. Biological parents, when they are given custody, are often struggling with their own drug abuse. When extended family member, such as grandparents, take on the responsibility of raising these children, they are given little if any programmatic support, such as respite care. Foster parents are given little information on how to respond to the atypical behavior these children present. When interactions between drug exposed infants and caregivers result in lack of attachments, rejecting or inconsistent care, children are at grater risk for developing mistrust, suspicion and fear. These attitudes may carry through to later stages of development.

RECOMMENDATIONS:

The incidence of prenatal exposure to drugs has been on the rise for the past decade, with some studies indicating 11% of the births in America. Yet, some of the children do need for adults to interact with them in special ways. Fortunately, existing programs for other high risk young children in general, provide some information on the qualities necessary to support children prenatally exposed to drugs.

The National Association for the Education of Young Children, as well as groups such as the Infant Association of California, the Perinatal Substance Abuse Council of Los Angeles County and the California First Chance Consortium have provided position statements that identify the qualities of a supportive environment for both young children and their caregivers. Our experience in the last 2 years as direct service providers along with the information just mentioned from the field of Early Childhood Education leads us to offer the following nine conclusion:

1. Early positive, responsive care is crucial for children's emotional and cognitive well being. Establishing a strong attachment with each child through understanding and acceptance is a teacher's major priority. Only in the context of a good attachment will a child's true potential be known.

2. While monitoring skill acquisition in the areas of language, social emotional, cognitive and motor development is necessary, it does not constitute an adequate assessment of the child's progress. The manner in which the child uses these skills during play, at transition time and while engaged in self-help activities is equally important. Close observation of a child's behavior at these times allows for the understanding of how he/she experiences stress, relieves tension, copes with obstacles and reacts to change. It provides valuable information on how the child uses peers and adults to meet needs and solve problems.

3. Different children respond to stress (internal or external) in different ways. Individual children show different responses to the same stressful events on different days. Teachers need to develop a sensitivity to the particular meaning different stressors have for the individual child and not have a predetermined set of expectations for or responses to child behavior.

4. The home is recognized as an essential part of the curriculum. Facilitating parental/caregiver goals helps to establish a close working relationship between home and school. Intervention strategies that strengthen positive interaction between child and family increases parental confidence and competency to raise the child and allows the child to benefit beyond his formal contact with the school.

5. Program intervention is best achieved when all professionals concerned with the child and family are coordinated. To accomplish this successfully, time must be allotted for teachers to meet and plan with assistants, and to work together in a transdisciplinary model with the support of social services, medicine, psychology, speech and language, and adaptive physical education.

6. Intervention strategies, to be effective, must attempt to counter balance prenatal and perinatal risk factors and stressful life events. To accomplish this the teacher must build in protective factors within the classroom environment and provide facilitative ways for young children to appropriately cope with stress. Self esteem, self control and problem solving mastery is best achieved when protective factors are coupled with a facilitative approach in the acquisition of better coping skills. These protective and facilitative factors are not dissimilar from what would be built into any good preschool program, but receive additional attention in this environment because drug exposed children are less resilient.

Respect. High risk children need a setting composed of nurturing adults who are respectful of children's work and play space, and who do not make unrealistic demands, nor unpredictably appear and disappear. In staffing programs for high risk children not all professionals will be available on a daily basis. Some important professionals (e.g. speech and language therapist, psychologist, social worker, etc.) come into the classroom weekly or less frequently to interact with the children. These adults should develop a routine for reintroducing themselves and predicting for the children when they will appear again. Consistent personnel who help children understand the visiting adult's schedule enhance a child's sense of security.

Rituals & Routines. High risk children need a setting which is predictable. Providing continuity and reliability through rituals, routines and scheduling activities to occur in a predictable order over time, strengthens a child's self-control and sense of mastery over the environment.

Regulated Limit Setting. High risk children need a setting in which the number of explicitly stated rules are limited. By limiting classroom rules, children are encouraged to explore and actively engage in their social and physical environment. While it is possible to teach specific objectives by relying on rules to control the child, it may be at the expense of the child's intrinsic motivation, problem solving capacity and self mastery.

Flexible Room Environment. High risk children need a setting in which classroom materials and equipment can be removed (reduce stimuli) or added (enriching the activity).

Transition Time Plans. High risk children need a setting in which transition time between different classroom events is seen as an activity in an of itself, and as such has a beginning, middle and end. Special preparation is given to this activity recognizing that transition times are one of the best times of the day to teach the child how to prepare for and cope with change and ambivalence.

Adult Child Ratio. High risk children need a setting in which the adult child ratio is high enough to promote attachment, predictability, nurturing, an on-going assistance in learning appropriate coping styles.

Attachment. High risk children need a teacher who accepts each child as he/she comes, with a history of both positive and negative experiences. A high risk child may have a history of poor attachments and lack of trust. The degree to which a child comes to trust the world, other people and himself/herself depends to a great extent upon the quality of care he/she receives. When care is inconsistent, inadequate or rejecting it fosters mistrust, fear, suspicion, apathy or anger towards the world and people in particular. These feelings will carry through to later stages of development.

Feelings. High risk children need a teacher who accepts that children have negative and positive feelings. Feelings are real, important and legitimate. Children behave and misbehave for a reason, even it if can't be figured out. In responding to a child's misbehavior. Doing so allows the child to recognize that his/her feelings ar real and valid. Being understood facilitates self esteem and promotes a willingness to function with prescribed limits.

Mutual Discussion. High risk children need a teacher who acknowledges that children's behavior, feelings and experiences are open to mutual discussion. Talking about behavior and feelings, (done with empathy rather than judgement) validates the child's experiences and sets up an accepting atmosphere. Permission to have these feelings leads to the increased ability to distinguish between wishes and fantasies on the one hand, and reality on the other. Verbal expression allows the child to integrate past and present events into a total experience. This integrating process leads to the child's increased ability to modulate behavior, gain self-control, and express his/her own feelings.

Role Model. High risk children need a teacher who understands that by establishing an individual, trusting relationship, the teacher becomes an important person, and behavior the teacher models is more likely to be imitated.
Peer Sensitivity. High risk children need a teacher who realizes that a child becomes sensitive and aware of the needs and feelings of others only by repeatedly having his/her own needs met.
Decision Making. High risk children need a teacher who recognizes that it is important for children to be allowed to make decisions for themselves. Freedom to choose and to assume the responsibility for those choices, gradually expanded in view of the child's physical, social, emotional and intellectual growth, promotes self-esteem, problem solving mastery and moral values.

7. When early intervention services are provided to drugs-exposed children and their caregivers, positive developmental outcomes are enhanced. These young children do better in school and in the home/community. If sporadic mastery and behavioral difficulties are not remediated during preschool years, they may not be remediable later. The children are more likely at this age to learn appropriate social, emotional, language and cognitive skills. Most drug exposed children are probably in the high risk category rather than developmentally disabled. We hope to prevent school failure by providing support early and consistently.

8. In order to successfully interact with Prenatally Exposed to Drugs (PED) children, specialized teaching and caregiving strategies are needed. The provision of simply serving them in a regular preschool or kindergarten environment without specialized help will not be sufficient to meet their needs.

9. Successful ways to interact with these children are teachable to parents, foster parents, extended family members, day care, preschool and kindergarten teachers as well as health and social service workers. In a sense, these children successes will depend on the number of adults in their world who are willing to behave in new ways. Ways that respond with respect to the child as a unique individual.

I would like to conclude these remarks by highlighting five areas of service delivery that need increased attention and development. First, programs to teacher "parents-to-be" about the impact of drug abuse on the developing fetus are critical. Second, increasing the prenatal care available to mothers who are abusing or have abused drugs is essential. Third, additional drug treatment programs for pregnant addicts are needed. I'm sure that testimony provided to this committee by experts in the area of prenatal care and treatment has defined the needs and justification in these three areas.

Two additional areas of needed development relate to training and services for the caregivers who are raising these children. First, support services for extended families who take on the responsibility of these children must be increased. Respite care, parent training and preschool services are just a few areas in which extended family members may need help. Finally, to reiterate a point made several times earlier, we must provide training to day care, headstart and child care personnel so that these children can function successfully in community preschool programs.

I hope my testimony has been helpful to the committee. I want to thank you again for providing an early educator the opportunity to share her ideas and experiences. Ultimately the development of these children rests on what we as a society are willing to invest in longitudinal services for them and their caregivers.

Respectfully submitted.

Carol

Carol Cole

On behalf of the Los Angeles Unified School Districts, Division of Special Education, Preschool Enrichment Development (P.E.D.) Team.

Carol K. Cole, M.A., Child Development Specialist/Teacher
Vicky Ferrara, Early Childhood Special Educator
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Valerie Wallace, M.A., Psychologist
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Testimony presented to the Select Committee on Children, Youth and Families, United States House of Representatives by Carol K. Cole on behalf of the Division of Special Education, Los Angeles Unified School District.

EXECUTIVE SUMMARY:

Los Angeles Unified School District began a pilot program for preschool children prenatally exposed to drugs in the spring of 1987.

The purpose of the program is to provide services to preschool age children who are quite competent cognitively, but defined as high risk because of prenatal exposure to drugs.

Through an enriched preschool experience, home school interaction and interagency cooperation, we are developing strategies designed to help these children believe in themselves, and also abide by the larger society's rules. These strategies can be taught to and implemented by the many adults who will interact with these children. We have attempted to provide a supportive environment where the children can learn to trust adults, to modulate their own behavior, to interact cooperatively with peers and to believe in themselves. We hope that if children learn these skills, they will succeed in school and later on in life.

The pilot now consists of three classrooms for children. Each classroom is staffed by three adults to a maximum of eight students. A psychologist, social worker, nurse and pediatrician are assigned to work part time with children and families. The children also receive the services of an adaptive physical educator and a speech and language therapist as needed.

FINDINGS:

We are recognizing that these children are as impacted by their environments as by the prenatal exposure to drugs. These children display a broad range of problems from severe handicapping conditions to risk factors. Exaggerated behavioral patterns are often a way a child copes with a situation that is overwhelming to him/her. These behaviors may continue in more aggravated forms unless the child receives intervention services.

These vulnerable children may display poor motor skills, delays in speech and language, poor problem solving, attention and concentration difficulties, inability to organize play and extremes in behavior ranging from apathy to aggression, from passivity to hyperactivity, from indiscriminate trust to extreme fear and suspicion.

Most of the children in the pilot program show episodes of disorganization, behavioral unpredictability and difficulties with attachment. While they may show these problems, they also have areas of typical development. They are more similar to their typical peers than they are dissimilar. In a sense the cognitive competence demonstrated by this group will not be enough, by itself to protect them against school failure.

RECOMMENDATIONS:

1. A quality preschool environment makes a difference for children prenatal exposed to drugs.

2. Strategies that are effective in helping these children cope and learn have been developed for classroom and home use.

3. These strategies can be taught to parents, foster parents, extended family members, day care, preschool and kindergarten teachers as well as health and social service workers.

4. Personnel from community preschool programs, e.g. Headstart should be trained to work with children prenatally exposed to drugs within their own program settings.

5. Services, such as respite care, and after school programs, should be provided to extended family members and foster families who take on the responsibility of raising these children.

6. Increased services must be developed for biological parents, including more available prenatal care, additional drugs abuse treatment facilities for pregnant mothers and parent/child education classes.

Chairman Miller. Ms. Meijer.

STATEMENT OF LUCIA MEIJER, SUBSTANCE ABUSE SPECIALIST, WAMI AIDS EDUCATION AND TRAINING CENTER AND PROGRAM, SEATTLE, WA

Ms. Meijer. Thank you. My name is Lucia Meijer and I want to thank Mr. Miller and Mr. Bliley for inviting me to testify here today.

I have worked in the field of substance abuse for close to 15 years as a counselor, administrator and now as an educator. I am currently substance abuse education coordinator at the AIDS Education and Training Center at the University of Washington School of Medicine.

I'd like to take this opportunity to emphasize the fact that the majority of AIDS cases involving women and babies are directly related to intravenous drug use; that the majority of these cases are black and Hispanic; that although new cases involving homosexual and bisexual men are declining, cases involving I.V. drug users and heterosexuals are increasing and the majority of these are black and Hispanic.

Today I would like to address some of the concerns of the committee regarding the ability and capability of existing treatment services to deal with the problems of addiction among women. I have worked over the last 15 years primarily with what are often referred to as hard core addicts and it has been my experience that treatment for women in this category is often not only unavailable but inadequate.

First of all although treatment services appear to be plentiful, women without financial support can only access a very limited range of these services. The largest single source of support for treatment comes from private, third party payers such as Blue Cross/Blue Shield and H.M.O.s.

Illicit drug users particulary female illicit drug users and even more particularly those who are pregnant and have children often don't have the family or job stability necessary to maintain private insurance. In fact, if we compare programs that are aimed primarily at illicit drug users to other chemical dependency programs, we find that these programs rely primarily on government support for funding. These programs are also the highest utilized and incidentally have the highest proportion of female enrollment.

I also believe like some of the other members that have testified here today that there is an underinvolvement of other health care and social services in the prevention and treatment of addiction. One reason for this I believe is that our understanding of addiction tends to be very narrow, there is a heavy reliance on self help approaches to treatment that are modeled after AA Fellowship approaches or therapeutic community families. This has had many benefits but it has also created a closed circuit perspective on addiction, that is, those people who experience success in self help programs go on to assume positions of responsibility and leadership in the field so that definitions of addiction and recovery tend to reflect the characteristics and experiences of this successful group. This can leave out many people who can't identify with the program characterization of addiction or who did not benefit from treatment methods offered.

It is my perspective that many of the people who don't fit in have been women. The reliance on these self help approaches is due at least in part to the fact that they are more cost effective than more individualized interventions that may require more expensive personnel and services.

Another influence that has increased the separation of substance abuse treatment from other interventions has been the overuse of a single model of addiction. This model often describes addiction not as a symptom of something else but as a primary underlying physiological disorder which makes the life of the affected person increasingly unmanageable. This model was first applied to alcoholics but was adopted by a wide range of profit and not for profit programs after treatment for alcoholism was approved for private insurance coverage.

However, there's increasing evidence that for many substance abusers addiction is in fact a symptom or a cofactor of a wide range of other conditions including underlying major depressive disorders, untreated health problems, dysfunctional relationships including physical, emotional and sexual abuse. For these individuals what is often the primary treatment approach to addiction can be a false hope.

In many programs the extent of specialized services for women is the addition of a women's group or assignment to a female counselor. The belief that all addiction has a common cause and course has discouraged the aggressive involvement of other health care and social service providers in the prevention and treatment of addiction.

I believe that there are few alternatives to the current system of treatment that can be developed that both encourage existing programs to be more responsive to the needs of women as well as develop new programs.

First of all I would recommend increased supports for specialized women's programs including the comprehensive perinatal substance abuse treatment programs that have been described today. I also suggest that we increase the ability of states to access treatment monies. In a recent article in the New York Times there was a report that there are $777 million in federal funds available to states for drug education and rehabilitation that have not been used and are due to expire on September 30th. The reasons given for failure of many states to apply for the money included a lack of state programs that the federal funds are intended to help and slow moving state governments that are confused by the federal formulas for allocating and using this money.

A third approach may be to focus funding opportunities on programs that service clients in low socioeconomic groups. A fourth alternative would be to provide federal leadership in the development of programs that use efficient and effective treatment methods by first of all increasing the ability of chemical dependency programs to recognize and treat a wide range of addictive behaviors and pre-addictive behaviors. Increasing the responsiveness of other provider systems such as mental health, public health, criminal justice, etc. to the problems of substance abuse. Increasing the coordination of services between substance abuse and other health care providers through partnership grants that encourage one or more agencies to pool resources and services and to explore the maximizing of resource utilization and effectiveness through case management programs that can provide centralized assessment, placement and case coordination functions for substance abusing clients referred by a variety of institutions including welfare, criminal justice, public health and mental health.

Thank you very much.

Chairman MILLER. Thank you very much.

[Prepared statement of Lucia Meijer follows:]

Prepared Statement of Lucia Meijer, Substance Abuse Education Coordinator, WAMI AIDS Education and Training Center, University of Washington, Department of Medicine, Seattle, WA

Substance Abuse Treatment and Women

My name is Lucia Meijer. I want to thank Mr. Miller and Mr. Bliley for inviting me to testify here today.

Despite an apparent proliferation of chemical dependency treatment programs throughout the country, there is reason to believe that females experiencing cocaine and other drug addictions may not be able to access or benefit from existing treatment services.

Treatment services are not uniformly available or utilized. The 1987 National Drug and Alcoholism Treatment Unit Survey (NDATUS) collected information on 8,690 facilities with a total of 614,123 clients on a given date (10/30/87) and 2,264,111 unduplicated clients over a 12 month period. The data in this report suggest that there are significant variations in treatment utilization, and that these differences may reflect a lack of availability of treatment to certain populations.

Treatment for people with primary drug abuse problems appears to be over utilized compared to treatment for alcoholics. The report describes three types of treatment programs: "Alcohol only facilities" (24%), "Drug only facilities" (14%), and "Combined alcohol and drug facilities" (62%). While the majority of programs fall into the combined alcohol and drug category, clients with primary drug abuse problems (43% of all clients) were far more likely to utilize a single type of facility (drug only) than their alcoholic counterparts (57% of all clients) who were more likely to utilize both alcoholism only and the combined facilities. Drug only facilities accounted for 55% of all drug abuse clients counted in the study and had the highest utilization rates (91%) compared to any other type of treatment. By comparison, alcohol only facilities accounted for only 39% of all alcoholism clients and were utilized at a rate of 83%, and the majority of alcohol clients (62%) were in combined facilities that had a utilization rate of 80%. Although there were far fewer drug only facilities than alcohol only facilities (1,075 versus 1,708), the drug only facilities were generally larger, reporting more clients in treatment. In effect, it appears that a significant number of persons in need of drug abuse services are accessing only a small percentage of treatment programs and that compared to other types of treatment, these programs are being highly utilized.

Differences in treatment utilization appear to be based, at least in part, on socio-economic differences in client populations. Overall, almost two-thirds of clients in the NDATUS study were white, however, black and Hispanic clients accounted for 41% of the drug abuse clients compared to only 25% of the alcoholism clients. Drug abuse clients were generally younger than alcoholism clients with clients under 25 accounting for 36% of drug clients compared to 26% of alcohol clients. About 28% of all clients in treatment were female, this is an increase from a previous NDATUS study that reported 22% female enrollment during 1982. Increases in female enrollment are most dramatic in drug treatment programs where the proportion of women was higher among drug clients than among alcohol clients (33% versus 24%).

Based on these figures, there appears that there is a significant segment of the chemically dependent population that cannot access a large segment of the total service system. The largest single share of financial support for all treatment services in the NDATUS was provided by private third-party payors (31% of all funds) such as Blue Cross/Blue Shield and HMOs overall treatment services suggesting that for many treatment is contingent on a certain degree of job or family stability. However, the largest source of financial support for drug abuse was State government, which included funds provided by ADAMHA through Block Grants and accounted for 27% of drug dollars, while the largest source of support for alcohol programs was private third party payments. Despite the fact that almost 80% of treatment programs are privately owned, government programs which represent only 20% of all services carry almost 30% of all clients.

Economic limitations on treatment availability may have a disproportionate impact on addicted women. There is increasing concern over the trend towards the "feminization of poverty". Studies of drug dependent women (Sutker 1981) indicate high levels of unemployment in this population (from 81% to 96%). Of the women in federally funded treatment programs most had not completed high school. Even after completing treatment, 72% continued to be unemployed and lacked necessary skills to get or keep a job. It has been argued that the female addict is likely to be even more socially and economically dysfunctional than her male counterpart because of cultural stigmas against female drug use that increase her isolation from family and other socio-economic supports.

Many female addicts are responsible for one or more children and this further limits their ability to access or utilize educational and vocational options. AIDS related studies reveal that of the IV drug users that were in relationships, the majority of women had partners who were also drug users while almost 80% of the male IV drug users had non-drug using partners. The female addict is less likely to be able to rely on a more stable partner for support, yet she is more likely to be responsible for the care of children. High pregnancy and birth rates have been documented among female drug users (Deren 1985) due in part to a lack of use of birth control, a belief that pregnancy cannot occur because of absent or irregular menses related to drug use, faulty perception of the early symptoms of pregnancy due to drug impairment, and the limited availability of publicly funded abortions, as well as personal resistance to the idea of abortion.

Few treatment programs are designed to meet the needs of women drug users. Because the actual number of women in treatment is small, and because female addicts are more likely to be in highly utilized drug programs, specialized services for the addicted woman have not been a priority in the treatment system. Perhaps even more importantly, many programs lack the flexibility and skills to develop relevant programming for women. Most treatment approaches are based on the characteristics and dynamics of addiction among male populations and comparatively little has been done to define the unique nature of addiction in women. If addiction is in fact, a complex interaction of biological, psychological, and social factors, then differences in gender should be a primary variable in how addiction is developed and sustained.

Many programs operate from a single model of addiction and recovery, although current research suggests strongly that different types of clients require different treatments. This does not necessarily require more programs, just more effective use of existing services. McLellan et al. (1986) found that within a single program, clients who were matched to specialized services according to a variety of individual characteristics did better than those who were not matched This prospective study also found that client-treatment matching methods made it possible to identify clients suited to less expensive outpatient and/or shorter term programs resulting in a more cost efficient use of resources ("Drug Abuse and Drug Abuse Research", The Second Triennial Report to Congress From The Secretary, Department of Health and Human Services).

"Marketplace" and other social influences have limited rather than expanded the scope of existing services, also limiting their ability to target special population needs. Despite an abundance of scientific research that supports the existence of multiple levels and types of addiction (Pattison et al., 1977, 1982, Nathan, 1981) a disproportionate number of programs emphasize a primary single treatment approach, usually based on the socially acceptable (and insurable) "disease model" of addiction. Among other things, the advantages of this model are that it removes the paralyzing stigma associated with addiction, encourages enrollment, and increases access to private insurance. Unfortunately, over utilization of any single model limits the ability of programs to effectively address the needs of a heterogeneous population. Just as a physician would not prescribe penicillin for every kind of infection, the substance abuse treatment system needs to develop a repertoire of primary interventions for dealing with different types of addicts. This should be distinct from single approach systems that are propped up by various "ancillary" services, or "scattershot" approaches that offer a variety of services without individualized matching of clients and services.

For many programs, the extent of specialization for women is to provide "women's groups" that are added on the primary treatment mode. These "add on" groups do not substantially change the overall context of the woman's treatment experience. All too often, the task of the women's group is to attempt to translate the prevailing treatment philosophy to fit their own circumstances as women. A more effective approach may be to design treatment goals, objectives, and procedures for women that are relevant to their particular needs and circumstances.

The effectiveness of existing programs to address the needs of addicted women may be increased through a better understanding and application of some basic principles of human behavior. There is a tendency in many programs to rely on the collective experiences of recovering addicts/alcoholics to formulate the guiding principles of treatment. Approaches that are viewed as intellectual or academic-based are not trusted. As a result, many programs have been criticized for lacking a firm theoretical base for their treatment techniques. Client success or failure is often attributed to something referred to as "motivation" although this quality is seldom measured or defined. The term "motivation" is often used as if it describes an intrinsic characteristic such as blue eyes or curly hair. There is reason to believe however, that readiness for change (or "motivation") is dependant on a number of internal and external variables that can be recognized and manipulated to optimize the health of the individual.

For any change to occur three conditions must be met:

1. **The person must accept that s/he has a need to change.** This is commonly approached through confrontive methods meant to "break down the client's denial." Research suggests that this method can have a negative effect on people with low self esteem (Lieberman et al., 1973, Miller, 1983, Fia and Shean, 1976, Feinstein and Tamerin, 1972). Low self-esteem is a characteristic often found in female addicts. A more effective approach may be a counselor facilitated self-assessment approach that teaches the woman to identify and personalize information about her problem behaviors and circumstances.

2. **The benefits of change must outweigh the losses.** However dysfunctional, most behaviors are connected to needs that are intensely felt. All too often concern for the female addict focuses on her role as a "vector" of harm to others, and not as an individual deserving of concern and compassion in her own right. The woman's needs for safety, relief from pain, affiliation with others, etc. are all integral to the process of addiction. Treatment cannot be effective if it does not address the needs that fuel the addiction by providing alternative, and more functional, ways for the woman to meet these needs. This means providing achievable options for change that balance needs and risks, rather than drastic "all or nothing" objectives.

3. **The skills and resources necessary for change must be accessible.**
   Recovery often requires that the woman change important relationships and familiar circumstances. This requires internal skills and external resources including cognitive training, self-esteem building, communications skills, medical care, parenting skills, vocational training, childcare options, educational and economic opportunities, etc. Skills and resources should be appropriate to the ability of the client to use them. For example, job training can be futile in the absence of reading skills.

A broader theoretical base for understanding addiction and recovery supports interdisciplinary treatment models that can greatly enhance the health of addicted women and their children. A study done by McLellan et al. (1981) found little relation between the severity of alcohol or drug use and the severity of other problem life areas. These results question the assumption that addiction is a progressive disease that leads to deterioration in overall functioning and suggest that "addiction may be a common pathway for a variety of specific disorders, rather than a general, progressive disease." Chemical dependency programs that typically focus on the drug and alcohol using behaviors as the primary agent of dysfunction may fail to recognize the for need medical, mental health, and social service interventions to the extent that they are necessary.

There exist numerous barriers to the utilization of other interventions in the treatment of addicts.

1. These services are very expensive compared to traditional treatment models that use non-professional staff and self-help cost efficient self-help groups.
2. Government funded services may be available at community health care clinics but this adds another layer of responsibility onto the already unstable lifestyle of the addict.
3. Non-substance abuse clinicians are accustomed to referring addicts to substance abuse treatment programs and have not developed specialized skills for working with addicts.
4. Substance abuse treatment providers are often distrustful of what they perceive to be academic or intellectual approaches to a problem that they have defined experientially.

RECOMMENDATIONS

1. **Increase supports for comprehensive perinatal substance abuse treatment programs**. There are only four programs specifically for pregnant addicts in the country -- one in San Francisco, one in Los Angeles, one in Chicago, and one in Philadelphia (Cohen, et al., The Journal of Drug Issues, Winter 1989). This does not begin to match the need for such programs in light of the current epidemic of cocaine addicted mothers and infants, and the increasing number of babies born with HIV infection.

2. **Increase the ability of states to access treatment monies.** A recent article in the New York Times reports that $777 million in Federal funds available to states for drug education and rehabilitation have not been used and are due to expire on September 30. The reasons given for failure of many states to apply for the money included "a lack of state programs that the Federal funds are intended to help and slow-moving state governments that are confused by the Federal formulas for allocating and using the money." (New York Times, Monday, April 17, 1989). If possible reduce the complexity of the application procedures, and provide Federal leadership to facilitate the use of these funds.

3. **Focus funding opportunities on programs that service clients in low socio-economic groups.**
Programs that target drug using populations appear to have the highest proportion of women in treatment. These programs rely far more on government funding than their alcohol or combined treatment counterparts that receive substantial private third party payments

4. **Provide Federal leadership in the development of programs that use efficient and effective treatment methods by:**
   a) Increasing the ability of chemical dependency programs to assess and treat a wide range of addictive and pre-addictive conditions through training and technical assistance programs. This may be administered through existing agencies such as the National Institute for Drug Abuse (NIDA)
   b) Increasing the responsiveness of other provider systems such as mental health and public health care to the problems of substance abuse through training and technical assistance programs. This may be administered through existing health education services.

c) Increasing coordination of services between substance abuse and other health care providers through "partnership" grants that require one or more agencies to pool resources and services.

d) Exploring the feasibility of maximizing resource utilization and effectiveness through "case management" programs that provide centralized assessment, placement, and case coordination functions for substance abusing clients referred by a variety of institutions including welfare, criminal justice, public health, mental health, and other providers. Existing TASC (Treatment Alternatives to Street Crime) programs have been providing these types of services for substance abusing offenders for over ten years.

Chairman MILLER. Ms. Cole, let me ask you how many children are in your program?

Ms. COLE. The program now serves 27 children.

Chairman MILLER. How many children are eligible? This is in the L.A. School District, right?

Ms. COLE. Right.

Chairman MILLER. You can provide exact figures later, but essentially what I'm asking is how many children are in the same predicament as these kids?

Ms. COLE. We actually have no statistics on how many children——

Chairman MILLER. How did you find these kids?

Ms. COLE. The children came into the pilot through referrals from foster mothers, hospitals and regional centers.

Chairman MILLER. This is the pilot program?

Ms. COLE. This is the pilot program, yes.

Chairman MILLER. That's a very dangerous word around here. As soon as you become successful we'll terminate you.

Ms. COLE. That's okay.

Chairman MILLER. It won't be your definition of success, mind you.

Ms. COLE. As a team we've struggled a lot this year in terms of that very issue. We were not looking to be expanded. We are looking to take some of the strategies we have developed in our program and educate caregivers whether they're parents, foster parents or teachers in ways to successfully work with this population. We are not recommending that we open up more programs.

Chairman MILLER. What's the cost of your program?

Ms. COLE. I don't have figures on the cost of the program. The funds to start the program came from the Division of Special Education and it costs no more than serving other children who are identified as being handicapped.

Chairman MILLER. I guess my concern is if your program, which obviously appears to be a very intensive program, if it in fact is the model that's going to have to be used or something like this model—there may be variations on that—but in terms of tending to these children when they start to become preschool and school age children with also I guess some prospect, that this would have to be continued for a number of years, that this may be conceivably K through 12?

Ms. COLE. Well——

Chairman MILLER. We don't know yet, right? We don't know quite what's going to happen later on.

Ms. COLE. You bring up some interesting issues that again we indeed struggle with. Inasmuch as the program that's in place now is more expensive because we have on our transdisciplinary team a school psychologist and a school mental health person who give us one day a week for the 27 children that costs more money. In the sense that we are also making recommendations that what we need to look for is not necessarily folks who have teaching credentials or people who are highly skilled to work with this population. We're very concerned about the teacher to child ratio in California. We're also very concerned about the need for academics in kindergarten which these children may not be able to do as well. The relationship and interactional difficulties these children show need attention as much as academics.

But it's not that much more expensive when we think in terms of long term-costs to society.

Chairman **Miller**. I understand that but let's think short-term costs. Because that's what the L.A. school district or the state or the federal government, however you put these funds together, is going to have to think about. What I'm suggesting is that the model is going to be reasonably successful in terms of the development of these children, again to what extent we don't know yet, what extent they will change with age.

I guess we don't know yet if those support services are necessary. You may substitute a noncredential person for a credential person but that person is still going to have some need of some professional support services in dealing with those children.

Ms. **Cole**. Absolutely.

Chairman **Miller**. So now you just take the child from this setting, mainstream them, to use the term that you use, handicapped back in to the classroom where they're going to draw upon the support services in that school site, maybe to a greater degree than other children?

Ms. **Cole**. Yes.

Chairman **Miller**. So I guess what I'm trying to suggest is that to do this right it's going to be very expensive?

Ms. **Cole**. Yes, I think it is. I'm not sure that it's going to be, however, any more expensive than picking it up at the other end in terms of, the welfare and penal systems.

Chairman **Miller**. No, it's just very hard where you dedicate money because the children can drift into the other system.

Ms. **Cole**. Absolutely.

Chairman **Miller**. They can just drift into the foster care system and they can drift into the institutional system and they can drift into the criminal justice system. That's easy. There's really no point of resistance to their doing that. But if we're going to try to see whether or not we can put these lives back together and have some semblance of a normal life for these children, we're going to have, it appears, we're going to have to stand with them all of the way along during their school age.

Ms. **Cole**. Yes. I do think we're looking at longitudinal investments.

Chairman **Miller**. And I'm just again, you know we like all of these programs, but I'm just concerned about whether or not we're prepared to fund them.

Ms. **Cole**. Some of the issues with regards to the children don't cost money in the sense that we need to train people to cross those agency lines and give permission for them to do that. So for instance in the role of teacher, my primary job description would be to impart information, not necessarily develop attachments. Certainly it is not necessarily to get on the telephone and ask the Department of Children's Service that when one of the children is to be moved into a new foster home could they please get another foster home within our school's boundary so that the child could continue in our program.

By doing that kind of interagency cooperation and advocating for that child we were able to stop that one child from having the experience of losing not only his foster mother of four years but also his school experience. That didn't cost any money.

Chairman MILLER. You're training him for free?

Ms. COLE. I didn't train the foster parent but I can pick up the phone and I think we need to educate teachers and personnel that it's important if you're advocating for those children to cross the definitions of your professional role.

Chairman MILLER. Do you have any school aged children yet in the program?

Ms. SHAMPLAIN. No.

Chairman MILLER. Do you anticipate given what you know of the population that's going to be necessary?

Ms. SHAMPLAIN. Eventually it will be necessary because with our ladies, once they complete our regular program, what we offer are transitional apartments, so those ladies can then stay under our guidance and then as those children grow naturally they're going to enter into a school system.

What I would like to do is comment on some of the feedback of Ms. Cole. I think it becomes important that for all the subsystems that the children may have tendencies to interface with is that there is some sense of an orientation or reorientation of professionals about crossing those kinds of lines.

It's been my experience in viewing state legislation that some time legislation they say if a person has a mental health problem, so I think what we may have to do is to go back some times and find that mental health include substance abuse or those other kinds of areas that tend not to be defined, but working with the children, because I have my A.L.P.H.A. Program, you know we work with the school aged children because we're working with children between the grades of 3 and 6 so I do have that exposure.

Chairman MILLER. Ms. Trupin, let me see if I understand your Grandparents here. Explain to me, on page 3 of your statement you have statistics for San Francisco. And you say in other words 953 children or 39 percent of the children in foster care in San Francisco are with family members. These numbers do not include those grandparents receiving Aid to Dependent Children so we have 953 children, what's the means of support?

Ms. TRUPIN. Well the grandparents——

Chairman MILLER. That's what you're calling unsubsidized?

Ms. TRUPIN. No. 953 are those children in foster care, that is 39 percent, there are in San Francisco about 2400 children in foster care. 39 percent of those children or 953 of those children are living with family members who are subsidized by foster care.

Chairman MILLER. All right.

Ms. TRUPIN. These numbers don't include grandparents or family members who are receiving A.F.D.C. and it also does not include all those grandparents who are caring for their grandchildren and receiving no funds whatsoever for whatever reason and I tried to point to some of those reasons.

And in our group there are about 35 percent of the grandmothers in our group are in that latter category, not receiving any funds whatsoever.

Chairman MILLER. So how are they supporting these grandchildren?

Ms. TRUPIN. Poorly. With difficulty.

Chairman MILLER. Are they prevented from receiving funds?

Ms. TRUPIN. Well, the grandparents, there may be a parent already receiving A.F.D.C. for care of that child.

Chairman MILLER. That's the case you described.

Ms. TRUPIN. That's the case and in the system, they may have applied to A.F.D.C. for foster care and the system, the bureaucracy is cumbersome and unwieldy and family members have a very low priority in that system. They are treated almost as if they are less deserving of this money than foster care parents who are not family members and so there's a lot of difficulties.

Chairman MILLER. So it's through the foster care system?

Ms. TRUPIN. Yes.

Chairman MILLER. Long-term foster parents and family members. What would be the A.F.D.C. level of support for one of the children, do you know, roughly?

Ms. TRUPIN. It's, I'm not sure, it's $300 or $400 a month and foster care is more like $600 a month.

Chairman MILLER. And do not provide either level of care maybe as much to continue this child in the system so there's this centrifuge floating around in there is $3,000 or $4,000?

Ms. TRUPIN. Yes, to put them in temporary shelters, you know——

Chairman MILLER. To maintain them in that system?

Ms. TRUPIN. Yes.

Chairman MILLER. Assuming temporary shelters means they're not there for 12 months but you've got to continue to process the child at the shelter.

Ms. TRUPIN. That process costs the county up to $4,000 a month. But you have to understand that grandparents even when they're subsidized their overall economic situation deteriorates in that of family even with subsidies. A lot of them work, employed in service related low paying positions and as a result of caring for their grandchildren they have had to quit so——

Chairman MILLER. I guess, most of my colleagues aren't here, I mean I continue to be at the point when I look at the foster care system and when I see these kinds of children in foster care system I don't know why we wouldn't give these grandparents $2,000 a month?

Ms. TRUPIN. That's right. They are the point of light.

Chairman MILLER. And I just don't understand this any longer—we're now going to take a child out that is poor and, to some extent in the case of the drug-addicted baby, disabled, we're going to put them with a poor person. I just don't understand this any longer especially when it appears that all of the costs that we're using to maintain this child in the system—and now I suspect these children will probably spend 15 to 20 years in the system—why we wouldn't seek out that permanency and quit worrying about somebody making a profit because everybody else in the system is making a profit. What do we care if the grandmother is able to provide for this child and do it on a first class basis and have an opportunity of adding to the permanency for this child and let the grandmother have some respite care? She may be able to go out and buy it out of her grant.

Ms. **Trupin**. She desperately needs it. It's one of the greatest needs as expressed in the group. These family members are on fixed and limited incomes and by caring for these children they have every right to this money and it's inefficient and foolish not to reward them with it and recognize the enormous contribution to this problem that they're making.

Chairman **Miller**. I think in all of our investigations in foster care I'm constantly worried about this balance between the incentive to keep a kid in the system and the incentive to spend the child out of the system into permanency and it may simply be that we ought to quit worrying as we did in the old days whether somebody was making a few dollars a month off of keeping a child. We ought to be so ecstatic that somebody will take a drug-addicted baby at this point. I'm not suggesting that we place them with crummy families. I think if we provide the kinds of financial provisions we will find we'll get better and better families, more and more stable families and more and more permanency for these children.

I have a lot of other opinions about what is happening to these grandmothers, there has to be some very, very selfish individuals but I guess we can't change that either.

Ms. Meijer, Mr. Rangel, when he left here, was grumbling, he does that quite often, but what he was grumbling about was there really aren't, we are not spending time, effort or money at the national level to develop models for this population of drug-addicted adults, well let's just deal with the drug-addicted adults, and with women in this predicament that those agencies should be dealing with this simply, he left with that's what we're not doing and your testimony seems to concur in his grumblings.

Ms. **Meijer**. Yes, unfortunately, when women enter the medical care system or criminal justice system or the welfare system the professionals in those systems sometimes feel that a referral to a community substance abuse program is going to take care of the problem, not understanding that that program has no more idea of how to deal with the special problems of the female addict than they do and that in fact if they were to get together and work in some kind of partnership then in fact there might be some more effective outcomes.

Chairman **Miller**. How do we change that? Can you do that by national modeling or is it a reeducation? It's not that people working the system aren't well intentioned. I'm not suggesting that at all but Ms. Cole indicates you have to do some retraining of teachers, you've got to do some retraining of grandparents, you've got to do some retraining of service providers, families.

Ms. **Meijer**. I think there's a few things. I think that training and education are extremely important on both sides of the fence. In other words, in the medical community and in the social service community as well as in the substance abuse community and in my job right now as AIDS/Substance Abuse Education Coordinator that's exactly what I'm trying to do around issues of substance abuse and AIDS. But I think there's something else that can be done too and this is a little bit more sensitive. I think because of the popularity of the disease concept and the fact that it is a way of removing the paralyzing stigma that's attached to addiction many programs have adopted the approach for that reason and that if we were to show a more broader level of compassion, a broader level of concern for addicted individuals, in other words, create a system in which somebody does not have to demonstrate that they have a disease before they are deserving of our help that that may encourage programs to look at wider range of addictive behaviors and solutions.

Chairman **MILLER**. Where would these children be without the grandparents in San Francisco?

Ms. **TRUPIN**. They would be with addicted parents or they would be with strangers in foster care.

Chairman **MILLER**. Would they be in foster care? Does San Francisco, does the Bay Area, Ms. Trupin?——

Ms. **TRUPIN**. In the case of extreme abuse where a three year old is taking old stale bread out of garbage can and feeding it to the 7 month old baby, which is what we have heard, the court will intervene and move for removal but as I tried to point out there is this marginal area in which because the courts are so swamped and because there's a shortage of workers the child is left with the addict parent to linger there in this situation of chronic neglect which I think should be redefined as abuse. So if there were greater social services the child could be removed from the home which isn't to say that the parents' rights are terminated but at least the child could be removed from the home and even placed with family members or in other kinds of shelters.

So it's that problem——

Chairman **MILLER**. But that's not happening, so these grandparents are filling the void?

Ms. **TRUPIN**. Exactly and the situation in which these grandparents are surfacing and really in enormous numbers to have the children, it's every scenario you could imagine, either all the time, some of the time, some subsidies, no subsidies, these grandparents are coming forward and other family members, its aunts and sisters and things, coming forward and fathers apparently in some cases are coming forward.

Chairman **MILLER**. Even fathers?

Ms. **TRUPIN**. Even fathers. We're seeing this.

Chairman **MILLER**. My. My.

Ms. **TRUPIN**. Even these grandparents——

Chairman **MILLER**. We should have a hearing on that aspect. That's revolutionary.

Ms. **TRUPIN**. It's small but noteworthy. We're seeing paternal grandmothers. It's often assumed it's the mother of the addict, family members are coming together. We see two grandmothers sharing the care of mutual grandchildren. Great grandmothers, 68-year-old woman with four great grandchildren with a 21-year-old addicted granddaughter left them and said I'll be right back and never returned. She returns and steals out of her purse and has the 8 year old stealing for her. It just goes on and on.

Chairman **MILLER**. Mr. Weiss?

Ms. **WEISS**. Thank you very much. Ms. Shamplain, in the course of your submitted materials you indicate that your organization has learned a great deal about cocaine, crack users and that it's impossible to treat them in a nonresidential program, that they have to be residential, that you can't deal with them on a 25, 30 day basis. It has to be a long-term residential basis.

And I know that you said your program is only in existence for about a year and a half at this point. Do you have any experience with what happens after released, people who have been in the program for these six to nine month programs. Is there a reversion to the use of crack, you know, or are they drug free after that? What's your experience?

Ms. **Shamplain**. My experience has been with I guess I'll digress a little bit is that what we found that working with the ladies in the residential program, that they tend to be most successful in the residential setting and that's because of their chronicity. We do have——

Chairman **Miller**. Because of?

Ms. **Shamplain**. Their chronicity. The long-term abuse of the drugs, right. And because they need such a structured setting then those individuals tend not to work well in out patient, that's why we designed the long-term model versus the 25 or 35 or 60 day model.

The first graduating class of ladies that we experienced, those ladies, three of the ladies, no four of the ladies are living with us in what we call transitional apartments. Because they're still saving money and they have not fully gotten on their own. They are renting apartments. We're splitting a lease with them. So they're still saving their money and they're living under our jurisdiction.

The three other ladies, no the other ladies are living on their own with their family members. One is married but we've had one relapse. One of our seven graduates did relapse and we made every opportunity to her to come back into the treatment program but she's refused thus far. But the ladies, once they complete our program, are involved in outpatient. It's mandatory that before you graduate residential you must attend an outpatient setting. The concept is to seal as many of the gaps as possible.

Additionally, the ladies are required to become involved in a narcotic anonymous and A.A. along with therapy. We try to do as much of the supportive environment as possible.

Mr. **Weiss**. Ms. Meijer, do you know of any on going or completed studies dealing with crack addiction and how to get off, what works, what doesn't work? Is any work being done in that field?

Ms. **Meijer**. There are studies and what they indicate is what the other individuals here have testified to which is that it appears to be the most resistant of all forms of drug abuse to treatment. And from my perspective there are two reasons for this. At least two reasons. And that is because drugs can be harmful both because they are impairing, in other words they impair the judgment and because they are rewarding so that people become engaged in drug seeking behaviors.

Most drugs are either one or the other. Crack cocaine happens to be both. It is both impairing as a drug, for example, like alcohol would be and it is highly rewarding. It is the most highly rewarding drug of all. And it has become part of an underground economy so that it is most concentrated in those communities where people have very few other rewards and very few, and are very vulnerable to impairment.

So the combination of the drug and the user characteristics and the setting in which all of this occurs creates a problem that is very resistant to standard forms of treatment.

Chairman MILLER. Do you know of any research studies underway to try to create a blocking mechanism as with the methadone regarding heroin?

Ms. MEIJER. There are treatments that will block the brain's ability to respond to heroin. Right now to the best of my knowledge there are not similar drugs that can block the brain's response to cocaine.

Chairman MILLER. Right, what I was really asking if you know if there's any kind of research being funded by anybody, state, federal government?

Ms. MEIJER. I'm not aware of research specifically geared to that. I am aware of research for the treatment of cocaine users that involves drugs that apparently increase the recovering person's ability to feel pleasure again in a normal way through the use of certain neural transmitter precursors, but not beyond that as far as I know.

Chairman MILLER. Okay. And Ms. Trupin, in the course of the program do any of your grandmothers deal with children who themselves have AIDS or the mothers who have AIDS. Is that part of the program or not yet?

Ms. TRUPIN. The grandmothers referred to our group, of those grandmothers that really is not an issue. I'm sure it's out there but that is not an issue in our group.

Chairman MILLER. Because we had our pediatric AIDS hearing, in Newark and in New York and Florida and Connecticut in fact there's this situation now where both the mother and the child or children are on their way to dying. It's the grandparent who is in fact being forced to care for both the child and the grandchild.

Ms. TRUPIN. The profile on the east and west coast is somewhat different with respect to AIDS and newborns and it's been indicated to me that grandparents are playing a large role in the same way we're seeing them on the west coast. They're playing it with respect to AIDS on the east coast, that there's this sort of missing link of who's really taking care of these babies. And the more they think about it they go that's right, it's the grandparents because you can account for great numbers within the formal system but there's some missing link of care and of course it's the family members and the grandparent in particular who is assuming this responsibility when you look at it more closely. This is an unacknowledged and to some degree invisible phenomenon and yet because the response that we've gotten from our work indicates that people really if they look at it for one second longer, realize the extent to which it's true nationwide.

The City of New York has 27,000 children in foster care so you can just extrapolate how many of those are with grandparents. This, the grandparent phenomenon, is a nationwide response to both crack cocaine and AIDS And it needs to be recognized.

Chairman MILLER. Thank you. Ms. Meijer, I know that Portland, I think it's Portland, has a needle exchange?

Ms. **Meijer**. I think you're referring to the program in Tacoma?

Chairman **Miller**. Is it Tacoma?

Ms. **Meijer**. I think so.

Chairman **Miller**. I knew it was out there some place, right? Seattle doesn't have one, does it?

Ms. **Meijer**. It just started one.

Chairman **Miller**. Is that right?

Ms. **Meijer**. It just began.

Chairman **Miller**. I'm glad Mr. Rangel is not here, he would be upset to hear that.

Ms. **Meijer**. Yes, it's spreading.

Chairman **Miller**. And again what's the Tacoma experience, can you tell us about that?

Ms. **Meijer**. I'll try and limit what I can say about it because it has an interesting history. It evolved from the efforts of a man named Dave Purchase who was involved in the community government and became frustrated with their unwillingness to do any prevention in the community so one day he bought about I think it was a case of needles from a drug supply company, borrowed a card table from a friend of his and set up the needle exchange program on the corner of a high risk area in Tacoma and although the use of needles for the purposes of illicit drug use is a misdemeanor in the state the police had the wisdom to refrain from enforcing that law to its fullest extent and there has been a phenomenal response from the addicts on the street not only in terms of using clean needles but a renewed faith in the willingness of the system to help them and to show tangible concern.

As far as its effect on seroprevalence it's very hard to measure because there is no way to take those needles that are turned in, the dirty needles and test them for the presence of virus or the virus antibodies.

At some point I would hope there would be funding to do a study of that nature to see whether or not seroprevalence goes up or down following exchange program.

Mr. **Weiss**. Thank you. Thank you very much.

Chairman **Miller**. Let me just ask, because I think I was working on an assumption. What do we know about whether these children are going to outgrow some of the behavior that you've described, Ms. Cole?

Ms. **Cole**. We really don't know too much about that.

Chairman **Miller**. Your six year olds are different from your two year olds?

Ms. **Cole**. We're looking at that. We feel by the time the children reach three years old and enter our programs what we're working with is a constellation of risk factors. The constellation of risk factors has much more to do with what happens to them after that prenatal exposure to drugs than the prenatal exposure itself.

Chairman **Miller**. Wait, wait, what are you saying? You're saying that after the exposure, after they're born, the question of what happens to them then they have a lot more than the fact that the addiction in and of itself that they may be put back into an environment where they're harmed on an additional basis because of——

Ms. **Cole**. Or multiple care takers. I mean even if we're talking about grandparents or in many cases with extended families in our program, the extended family may be an aunt a cousin or a grandparent that are sharing custody of the child but for the child that's three different caregivers.

Chairman **Miller**. I understand. That's what I meant by the environment whether there was an abusive environment or multiple care givers or they're right back into a drug environment because some of those care givers may also be using drugs, may have a different level of stability or what have you that they may be able to present.

So you're suggesting putting that child back into that environment poses——

Ms. **Cole**. Absolutely. I think it's a very complicated picture. Ten years ago I was working at a pilot project for children who had been identified as abused and neglected, also ages 3 and 4, and when went we back over the statistics in that study, 85 percent of those children were drug-exposed children. We just weren't looking at that criteria at that point. Of those children I have followed several who are now 17 years old, and they range from a child who is functioning in a gifted program to a child who is in a nonpublic school placement and is defined as incorrigible and shows no remorse at this point.

So, I think you're going to see the range of behavior with these children. What concerns me is we kind of have to talk out of both sides of our mouth at the same time. We've been involved in training Department of Children's Service workers and speaking to a lot of different folks about this population. On the one hand if you say there's really not too much wrong with this group of kids, they're really very typical in a lot of ways, we're not going to get the services that we need.

If we talk too much about their being drug exposed you get a whole group of people, teachers in particular, at times that throw up their hands and say what can I do about them, they're already drug exposed? Studies going on in Hawaii, particularly looking at high risk children who are successful show one out of four succeeded. They looked at what characteristics of those children had that made them successful. They found out, interestingly enough, that part of it had to do with the child's temperament, but just as important it had to do with the fact that there was one person in that child's life who became that child's advocate, whether it was a Sunday School teacher or school teacher or family member so that I think as teachers we no longer can say what can we do, there's nothing we can do because they go home to a bad situation. It's just not true anymore. So that whatever impacts that child's life from the point that he is born, I think will result in the kind of child that is produced.

Chairman **Miller**. Let me ask you this, are we seeing, what do I want to say, I guess clinical disabilities in these children because they're being born drug addicted in terms of what you would associate with children who are in special education, handicapped groups?

Ms. **Cole**. I'm glad you asked that. In California if a child is born with a disability they will be served starting at age 3 in the public school system so some of the children who were prenatally exposed to drugs do have strokes in utero, wind up being physically handicapped and being served in classrooms for children that are physically handicapped. Others are so impaired so as to never walk or never talk again. The study that we started had to do with the children who essentially would have slipped through the cracks if we weren't looking at them and the ones that we suspect constitute the majority of children so that they have risk factors not necessarily severe but are the ones that are impacting the regular kindergarten classes, the Head Start programs, the day care. Teachers and adults that work with them say there's something wrong, but they can't put their finger on it necessarily. This begins again that whole continuum of interactions that result in by the time the child is in the third to fifth grade, him being referred to classes for severely emotionally disturbed students.

So again the cognitive capabilities of these children are not going to be enough, as I said before, to really keep them from school failure.

Chairman MILLER. So we can look forward to those expenditures during the educational life of the child, assuming the child stays in school.

Ms. COLE. Assuming he stays in school, yes.

Chairman MILLER. Thank you. Thank you for making my day. Thank you very much. This is obviously as you can see for us a difficult issue but I think you've been very, very helpful in terms of putting it into some perspective for those of us who are supposed to be making policy around some of this and I think also helped us pull it apart a little bit to separate it as we go down the road here making some decisions about funding and the types of programs. This will slow us down a little bit in terms of some of our reactions to this especially if it's going to continue somewhat in a somewhat unabated fashion that it appears to be. Thank you for traveling all this way and being with us and sharing with us your knowledge.

Thank you.

The meeting stands adjourned.

[Whereupon, at 1:43 p.m., the select committee was adjourned.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF THE HON. CURT WELDON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

I would like to thank the chairman for his selection of such an important topic for today's hearing. Clearly, Congress must take a critical look at the services being provided to pregnant women, especially those who are substance abusers.

Unfortunately, no one can deny that drug use by pregnant women is prevalent, nor can they contend that such use poses no risk to fetuses. Sadly, there is no debate about this problem. The real truth of the matter is that more and more children are being born to mothers who use cocaine, and those children are more likely to be born premature, have low birth weight, and show a decreased response to stimuli.

Clearly, this is a population which would seem to need specialized drug and alcohol treatment services. I am sure that many who review the testimony today will be favorably inclined toward the initiation of a large, Federal program for pregnant women on drugs.

After carefully reviewing the recent study by Dr. Ira Chasnoff regarding cocaine use in pregnancy, I have concluded that such a program would be well intentioned, but not necessarily effective. Dr. Chasnoff's study seems to indicate that the impact of drug use on the fetus occurs primarily in the first 3 months of gestation and concludes that even cocaine exposure in the first 3 months "places the child at risk for neurobehavioral outcome and may have implications for long-term development."

Dr. Chasnoff's paper concludes that women who used crack only in the first 3 months of pregnancy gave birth to children with similar rates of birth defects as women who used cocaine during the entire pregnancy. Because many women, especially drug users, do not discover that they are pregnant until several weeks into the gestation period, specially targeted programs to deal with this population may be too late. The first few weeks of the pregnancy are critical to the healthy development of a child, making drug use prevention programs targeted to pregnant women ineffective in protecting the health of the unborn.

Given the difficulties which such specially directed programs would have, I believe that more effective programs are ones which target at-risk groups for drug abuse treatment and prevention education.

I am glad to report that this administration and this Nation have extensive programs to combat drug abuse. In fiscal year 1987, America spent $1.8 billion on drug abuse treatment and prevention. 51 percent of that money came from the State Governments, and the Federal Government contributed an additional $324 million.

I am also glad to report that President Bush has committed $735 million dollars for drug treatment activities for fiscal year 1990, an 18 percent increase over the current year. The President has also requested $30 million for a grant program to target youth and indigent expectant mothers for drug treatment.

There can be no denying that drug use by pregnant women poses tremendous risks and problems. The children are often born addicted to drugs, have low birth weights and higher mortality rates, and are less responsive to stimuli. They are often left to the care of the mother's relatives, and the more extensive medical and educational needs of the children increase their burden on society. All this, Mr. Chairman, is an unfortunate truth.

What is not so clear, however, is whether there is a need for a special Federal program to treat pregnant women. By the time most substance abusing women discover that they are pregnant, the damage has already been done to the fetus. Attention must be paid to general education and prevention programs.

Such general responses, though not specific to perinatal substance abuse, are the most effective weapons to fight it. They are also the initiatives which the Bush administration has chosen to pursue.

Thank you, Mr. Chairman, for calling this important hearing. I look forward to a lively and informative presentation by today's witnesses.

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May 11, 1989

Congressman George Miller
Chairperson, Select Committee on
Children, Youth, and Families
385 House Office Building Annex 2
Washington, D.C. 20515

RE: Illegal Drug Use In Pregnancy:
Legal and Health Policy Issues

Dear Congressman Miller:

Thank you for inviting me to submit a written statement. I am a lawyer specializing in health law issues affecting low-income women, and have published several articles on drug use and pregnancy. Currently, I am the Revson Fellow in Women's Law & Public Policy at the National Health Law Program.

I am submitting a legal analysis of this issue that differs substantially from that presented to the Committee during the hearing. I am deeply concerned that the oral analysis presented to the Committee misrepresented the current state of the law, misled the committee as to the available legal options to address the crisis of drug use during pregnancy, and glossed over the very serious legal and health policy issues raised by attempts to punish pregnant women.

My statement will address two issues: (1) the legal status of the fetus in the law, and (2) the legal and health policy concerns surrounding punitive sanctions against pregnant women for behavior potentially harmful to their developing fetus.

Very truly yours,

Molly McNulty

Molly McNulty
Staff Attorney/Revson Fellow

FUNDED BY THE LEGAL SERVICES CORPORATION

PREPARED STATEMENT OF MOLLY MCNULTY, ESQ.,[1] REVSON FELLOW IN WOMEN'S LAW & PUBLIC POLICY, NATIONAL HEALTH LAW PROGRAM, WASHINGTON, DC

ILLEGAL DRUG USE IN PREGNANCY: LEGAL AND HEALTH POLICY ISSUES

Molly McNulty, Esq.[1]
Revson Fellow in Women's Law & Public Policy
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My statement will address two issues: (1) the legal status of the fetus in the law, and (2) the legal and health policy concerns surrounding punitive sanctions against pregnant women for behavior potentially harmful to their developing fetus. I conclude that punitive sanctions would be unfair, ineffective, and probably unconstitutional. A more effective use of the law would be to create universal access to health care for pregnant women.

In brief, my points are as follows:

I. The Legal Status of the Fetus

-- The fetus is not a legal "person."

-- In the limited legal situations where the interests of the fetus are recognized, the purpose is to compensate the parents, not to blame the mother.

-- The U.S. Constitution requires that the mother's actual constitutional rights be balanced against the state interests in potential life.

II. The Effects of Punitive Sanctions

-- Punitive sanctions probably would be ineffective, if not downright counterproductive.

-- Punitive sanctions are grossly unfair given the national crisis in access to treatment for pregnant addicts.

-- Punitive sanctions are probably unconstitutional, because they override a woman's constitutional rights to liberty, privacy, and equal protection without a compelling state interest.

III. Recommendation

-- The sole appropriate legal response to the crisis of drug use during pregnancy is to establish universal access of pregnant women to health care.

I. The LEGAL STATUS OF THE FETUS

A. The "Born Alive" Rule

Historically, Anglo-American law did not recognize the fetus as a legal being until it had been "born alive." In the past decade, as Mr. Parnese noted, this doctrine has eroded in criminal and personal injury ("tort") law. However, the rationale for new recognition of fetal interests in the law is not to protect "fetal rights." The reason is to protect the parents' interests who have lost their child because of a third parties (often a doctor, or assaulter) negligent acts. Courts have rejected legal doctrines that seem to put the mother and her fetus in conflict. For example, the Illinois Supreme Court recently held that a child could not sue its own mother for prenatal injury, observing that although a third person may be held liable for prenatal injuries, the relationship between a pregnant woman and her fetus is unlike that between any other plaintiff and defendant. "No other defendant must go through biological changes of the most profound type . . . in order to bring an adversary into the world."[2]

Thus, the unique relationship between mother and child limits the extent to which their rights can be set in opposition.

B. The Balance Between The Mother's Constitutional Rights And The State's Interests

The U.S. Constitution requires that the mother's actual constitutional rights be balanced against the state interests in potential life. Punitive sanctions against pregnant women may run afoul of constitutional requirements, including prohibitions on vagueness, guarantees of liberty and privacy, and rights of equal protection.

1. Constitutional Rights

A. The Right To Notice

The prohibition against vagueness requires that a person have reasonable notice of what is prohibited, so that she may act accordingly.[3] Many severe harms can be incurred by the developing fetus so early in pregnancy that women do not even realize that they are pregnant, and that their behavior might be harming their unborn child. Lack of notice would be a particular problem for drug-dependent women, who often do not realize they are pregnant because of lack of education and unfamiliarity with the signs of pregnancy, irregular menstrual periods, and the psycho-biological processes of repression and denial.

B. The Right To Liberty

The constitutional right to liberty contains several guarantees that are relevant to women faced with punitive state action for harm to their fetus.[4] Guarantees of liberty include the fundamental right to privacy, which has been established firmly under the equal protection clause and the substantive component of the due process "liberty" guarantee of the federal Constitution. The right to privacy includes the right to bodily integrity,[5] the right of parental authority against the state,[6] and the right to make childbearing decisions.[7] "[I]n order to enforce fetal rights or state regulations dictating behavior during pregnancy, the state would necessarily intrude in the most private areas of a woman's life."[8]

C. The Right To Equal Protection

In addition to violating women's right to liberty, criminal statutes proscribing certain maternal conduct during pregnancy may also violate women's right to equal protection of the laws.[9] Prosecuting women for failing to care for themselves during pregnancy revives damaging stereotypes of women as "vessels of the race" which historically have undermined women's equality.[10] The Supreme Court has announced that archaic rules and stereotypes may not be the basis for gender distinctions.[11] When women are valued solely for their reproductive capacity, justifications of romantic, paternalistic state control of women are reinforced.[12] Romantic paternalism distorts the state's efforts to improve healthy fetal development by focusing on women's actions as the sole factor affecting fetal health. In fact, men can have a powerful effect on fetal development, and therefore nondiscriminatory efforts to improve fetal health should focus on the responsibilities of both sexes.[13]

2. State Interests

As concerns over drug use and other harmful behavior during pregnancy have grown, legislators and other concerned advocates have struggled to define new state interests that express their concern. Such newly perceived state interests include the "protection of potential human life,", the "right to be born with a sound mind and body," and the enforcement of legal maternal duties toward her unborn child. Unfortunately, these three tools for various reasons cannot stand.

However, these state interests cannot effectively be translated into law. The first two state interests - protecting the potentiality of human life, and the right to be born with sound mind and body - are necessarily limited by our society's commitment to individual liberty and bodily integrity. No person is required to be the guarantor of another person's quality of life and health, because such a principle would require excessive coercion over other people's lives. The third state interest is dangerous because of its limitless properties.

Illegal drug use is not the only behavior that carries risk of fetal harm. Though not as widely publicized, alcohol abuse during pregnancy is a much more widespread and more damaging phenomenon. Likewise, many other maternal behaviors during pregnancy carry a risk to a developing fetus. Examples include smoking a cigarette, driving, working, or simply staying on one's feet too long. The principle inherent in these newly expressed state interests ultimately would force all women of child-bearing age to live as though they were perpetually pregnant, with the most extreme restrictions on their liberty.

II. THE EFFECTS OF PUNITIVE SANCTIONS

A. Ineffective

Punitive sanctions probably would be ineffective, if not downright counterproductive. In the states that have attempted to criminally punish women for harmful behavior during pregnancy, or which have policies of automatically depriving women who use drugs of their newborn babies, reports abound of frightened women who refuse to come into treatment for fear that they will lose their children, their liberty, or both. If the goal of legislative attention is to prevent birth defects and to halt maternal drug use, the sole way to achieve that end is to provide treatment and education for needy women.

B. Unfair

Given the national crisis in access to adequate prenatal care and drug treatment for pregnant addicts, punitive sanctions are wholly inappropriate and bitterly unjust.

The population at which punitive actions are targeted tend to be the victims of neglect of our health care system, often on the fringes of society, beyond the reach of concerned health care workers. Access to prenatal care in America is poor and unequal, especially for low-income and minority women. Medicaid is inadequate to serve as a safety net for the growing number of women who lack private insurance because it covers only forty percent of women below poverty, because lack of obstetric participation in the program is reaching crisis proportions, and because burdensome paperwork and reimbursement delays continue to drive both physicians and patients away. With respect to the dilemma faced by drug dependent pregnant women, most prenatal care centers do not treat addiction, and most treatment centers do not treat pregnant patients because they lack childcare facilities and fear obstetric malpractice from "high-risk" pregnancies.

Until the study presented by Dr. Wendy Chavkin, no data existed to document the shocking extent to which pregnant women with drug problems lack access to any treatment. Only a handful of specialty treatment centers exist in this country to treat this huge population of needy women. Though successful, they are far too few to preserve the health of all the needy women and their future children. In light of the declining availability of health care, a law that punishes women for the consequences of inadequate prenatal care would be a bitter injustice.

C. Unconstitutional

When a state law regulates the exercise of a fundamental right, the state has the burden of demonstrating that the law is necessary, is narrowly tailored, and will serve to promote a previously recognized compelling state interest.[14] Assessed against this standard, laws criminalizing or punishing drug use during pregnancy probably would be unconstitutional.

Because fundamental rights to privacy, liberty, and equal protection are involved, and because women have some constitutional protections as a minority, the state must demonstrate a compelling interest. This means that there must be a close "fit" between the goal of the law and the means to achieve it.

If the goal of punitive sanctions against drug-dependent pregnant women is to prevent birth defects, the method is irrational, because the method is more likely to deter women from medical care than to encourage them to seek it out. If the end is purely to punish pregnant women who use drugs, the statute likewise may be unconstitutional because it penalizes women because of their childbearing status.

III. RECOMMENDATIONS

The extent to which this country disgracefully neglects children and mothers has already been documented extensively by the Children's Defense Fund and the National Commission on Preventing Infant Mortality. Imposition of sanctions on marginalized pregnant women compounds this bitter injustice, violates the legal principles of this country, and will worsen - not improve - the health of our babies and mothers.

A far more appropriate way to preserve the life and health of our country's babies and their families is to make a genuine, long-term commitment to health care and support services for these needy women and their babies. Hard choices about the allocation of resources in our society must be made if legislators genuinely are concerned about helping drug-dependent pregnant women and their future children.

ENDNOTES

1. J.D., New York University, 1988. Author of *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, New York University Review of Law & Social Change (Vol. 16, 1987-88); *Combatting Pregnancy Discrimination in Access to Substance Abuse Treatment for Low-Income Women*, Clearinghouse Review (May 1989); *Crisis In Access To Substance Abuse Treatment for Poor Women*, Health Advocate (Spring 1989); *Women: Pregnancy, Drugs & The Law*, Christianity & Crisis (forthcoming May 22, 1989).

2. Stallman v Youngquist, No. 64957 (Illinois Supreme Court, November 21, 1988), 57 U.S.L.W. 2341 (Dec. 13, 1988).

3. *United States v. Harris*, 347 U.S. 612, 617 (1954).

4. For a discussion of how criminal statutes that punish women for negligent or reckless conduct that harms fetuses may violate maternal privacy rights, *see* Note, Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse," 101 Harv. L. Rev. 994 (1988). *See generally*, *Johnsen*, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection, 95 Yale L.J. 599, 601-02 (1986) (comprehensive review of ways in which assertion of fetal rights in various contexts violate woman's constitutional rights).

5. *See* *Roe v. Wade*, 410 U.S. 113 (1973); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); *In re* Conroy, 98 N.J. 321, 360-61, 486 A.2d 1209, 1229 (1985); *Sup't of Belchertown State School v. Saikegicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977). *See also*, Stearns, Maternal Duties During Pregnancy: Toward a Conceptual Framework, 21 *New Eng. L. Rev*. 593 (1985-86).

6. *See* *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *Santosky v. Kramer*, 455 U.S. 745 (1982).

7. *See* *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

8. *Johnsen*, *supra* note 4, at 619.

9. U.S. Const. amend. IV, § 1.

10. *See e.g.*, Gallagher, Fetal Personhood and Women's Policy, 10 Sage Women's Policy Studies 91,104 (1985) (reviews "powerful and largely unacknowledged social attitudes in which pregnant women are viewed and treated as vessel"); Annas, *Protecting the Liberty*

of Pregnant Patients, 316 New Eng. J. Med. 1213, 1214 ("Before birth, we can obtain access to the fetus only through its mother, and in the absence of her informed consent, can do so only by treating her as a fetal container, a nonperson without right to bodily integrity.").

11. Mississippi University For Women v. Hogan, 458 U.S. 718, 723, 725 (1982) (a gender-based classification must be "applied free of fixed notions concerning the roles and abilities of males and females. Care must be taken in ascertaining whether the statutory objective itself reflects archaic and stereotypic notions.").

12. See, e.g., Muller v. Oregon, 208 U.S. 412 (1908).

13. For example, pre-conception injury may cause genetic damage to the sperm. Bertin, High Proof Paternity, Health 20 (June 1988) (father's drinking during conception affects baby's birthweight).

14. City of Akron v. Akron Center for Reproductive Health 462 U.S. 416, 427 (1983); see also H.L. v. Matheson, 450 U.S. 398, 413 (1981); Skinner v.Oklahoma, 316 U.S. 535, 540-41 (1942); United States v. Carolene Products Co., 304 U.S. 144, 152 n.4 (1938).

PREPARED STATEMENT OF RICHARD S. GUY, M.D., COCHAIRMAN OF THE MAYOR'S ADVISORY BOARD ON MATERNAL AND INFANT HEALTH, WASHINGTON, DC

I am Richard S. Guy, M.D. I am co-chairman of the Mayor's Advisory Board on Maternal and Infant Health. (District of Columbia) The board consists of representatives from the public sector as well as private providers and consumers. The current Advisory Board has representation from the District (state), federal and private sector. (See Attachment A)

The District of Columbia has long been challenged by the persistently high infant mortality rate for much of the last two decades.

Although there have been some fluctuations the overall trend has been improving: in 1975, for example, the infant mortality rate was 28.6; it was 24.6 in 1980, 21.4 in 1986 and in 1987 (the most recent year for which final data are available), the IMR was 19.6 deaths per 1,00 live births. This decline was registered in the same year that the District put in place an aggressive nine point plan aimed at improving pregnancy outcomes of District residents. As detailed in attachment B, these actions were clearly focused on bringing more high-risk women into prenatal care early in pregnancy and in providing them with a rich array of support and assistance.

This testimony is to report to this select committee of the fact that illegal drugs in our community are damaging even the smallest and the most vulnerable of our citizens and that the nightly homicides, so vividly reported each day by the media, are matched by equally distressing losses among the area's infants and their mothers.

My concern is focused in particular on drug use during pregnancy which appears to be on the increase in the District. The drugs in question are principally cocaine and "crack cocaine" but other drugs that are causing problems are alcohol, PCP, heroin, marijuana and cigarette smoking.

Use of these drugs during pregnancy poses a threat to maternal and child health in several ways:

- compromising the growth and health development of the fetus

- by triggering pretrerm labor and birth (a risk posed by cocaine in particular)

- by making the pregnant woman less able to care for herself and her developing fetus appropriately

- by rendering the new mother unable to provide adequate care and nurturing to her newborn baby
- by increasing the risk of death in the newborn through low birth weight, health problems in infancy derived from maternal drug use and improper care in infancy

REMEDIAL STEPS

The advisory board has proposed three modest initiatives to help ease the burden of drug use in pregnancy and post partum to help sustain the recent decline in the District's rate of infant mortality. These suggestions should be viewed as supplements to other initiatives, both local and federal, to reduce the distribution, use and demand for illegal drugs.

1. Establish residential, comprehensive drug treatment centers that give top priority to caring for pregnant substance abusers.

Treatment facilities for substance abusers are in very short supply. Generally, within the District, pregnant women are not routinely given top priority at all the facilities that do exist and there is a particular shortage of residential, "inpatient" treatment services, despite the consensus that intensive supervision is more likely to be effective than episodic "outpatient" care.

A recent study of the treatment facilities in the District reported in the Washington Post, showed that these centers are geared to treat heroin addiction. The clients come into the facility, give urine and then are given methadon and sent on their way. They are not set up to treat cocaine addiction which requires intensive counseling and supportive therapy. This requires trained personnel that are not available in the clinics. In the last report, that I am privy to, there were 14 unfilled slots for trained drug counselors in the existing clinics but they cannot attract candidates due to the low pay scale.

2. Provide mid-level care facilities for newborns to ease the nursery bed shortage at area hospitals.

One consequence of substance abuse is an inability of the mothers to care for their newborn babies. Many of these babies require hospitalization and careful observation for several days or a few weeks after birth before they are able to go home. Unfortunately, drugs have often destroyed these homes and the babies are left to board at the hospital. Such care is often very expensive and uses scarce medical resources to care for a social problem.

The problem of "long stay" has been going on for over a year at Howard University Hospital. The fiscal year-to-date occupancy of the newborn nursery for 19 8 was 114%. There have been numerous occasions when there were 40-46 infants in the nursery instead of the 35 maximum. Occupancy rates for the nursery for the last six months of 1988 are shown below.

Months	Occupancy Rate	Average Stay For All Admissions
July	119%	11.3 days
August	114%	12.6
September	121%	10.8
October	113%	10.8
November	118%	14.8
December	132.6%	17.1

A similar scenario and trend are also apparent at D.C. General and Greater Southeast Community Hospitals.

Scarce medical resources could be saved and more appropriate care could be given to these "boarder babies" if funds could be invested in some out-of-hospital, mid-level care facilities for such infants. By relocating older, healthier infants to such centers, the shortage of nursery beds for truly needy infants could be eased. In the absence of such placement spots, District hospitals must continue to over-crowd their newborn nurseries and strain their abilities to care for truly ill infants. The nursery bed shortage resulting from the increase in high-risk deliveries and boarder babies has become so acute that several times within the last year, D.C. neonatologists have not been able to locate an acute neonatal nursery bed between Richmond and Philadelphia.

The Mayor's Advisory Board has suggested additional actions to improve maternal and child health. Although these initiatives would also help in the substance abuse and pregnancy domain, they, have applicability to low income, high-risk- families generally.

4. Expand Medicaid eligibility to include pregnant women up to 185% of the federal poverty level.

it is well documented that one of the major reasons why low income women fail to receive prenatal car is that they have no way to pay for it. In particular, they may have no private health insurance or, if working or, married, be too "rich" to qualify for Medicaid. Nationally, some 15 million women ages 15-44 have no insurance to cover maternity care and two-thirds of these women - 10 million - have no insurance at all.

The District is already committed to covering maternity care and pediatric care for infants to age 1 up to 100% of the poverty level. The challenge is now to cover women whose income fall between 100-185% of poverty, as now encouraged by the 1987 Omnibus Budget Reconciliation Act. To date about 11 states, including Mississippi, have chosen to cover this additional population.

The health care consulting firm Lewin/ICF developed an estimate of cost of coverage of pregnant women and children under one year whose incomes fall between 100% and 185% of poverty at between $2.14 and $2.766 million for one year. The District's share would 50% of that figure. The Lewin study used FY 1987 data. FY 1990 cost would be at least 5% higher. The study estimated that between 840 and 1000 women and children would be added to the Medicaid rolls.

The Mayor made a commitment to add the funds for the above but the budgetary process siphoned off the money to fight the "drug war".

Other issues of the drug problem should be discussed. Sexually transmitted diseases are on the rise. Syphilis, Aids and gonorrhea are appearing more and more in the teen age segment. I had a patient whose 15year old daughter was found in a "crack house", brought there by her 20 year old aunt, having sex with anyone who would buy her crack.

A 4 year old had been left outside all day. When asked if his mother was out trying to score "coke" he said "no she is out looking for weed".

A first grader hid his mother's needles and syringes before he went to school. She came into the classroom screaming "where are my works' and threatened him with bodily harm.

I am aware, and I am sure that the committee members realize, that the above problems are not isolated to the District. Every large metropolitan area is facing the same scenario. The District, however, is the nation's capitol and congress is mandated to oversee the well being of its citizens and to assure the safety of it's streets.

I would think that the area of infant mortality would cause great concern for the members of this select committee. The District needs help in the solution to this problem. All of the studies and suggestions for the solution will drop by the wayside if the funding is not available for their implementation.

Federal leadership, in the form of a pilot project, is needed to show the way as to how best to prevent the loss of another generation of children, our most precious resource.

ATTACHMENT A

MAYOR'S ADVISORY BOARD ON MATERNAL AND INFANT HEALTH

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Judy F. Wilson, M.P.H.
WIC State Agency
Commission of Public Health

ATTACHMENT G

In 1987, Mayor Barry and Public Health Commissioner Reed Tuckson initiated a nine point plan to accelerate the decline in infant mortality in the District and, in particular, to focus services on high-risk women and communities. The plan included the following actions:

-- Operating a Maternity Outreach Mobile (MOM) van that will provide an outreach services in the areas of education, referral, follow-up and transportation.

-- Extending Medicaid eligibility to cover all pregnant women and infants under one year of age with family incomes above AFDC level but less than the national poverty level.

-- Extending the hours of operation in CPH clinics that are located in areas where the infant mortality rate is highest. The Benning Heights and Congress Heights clinics will remain open until 8:45 on Wednesday evenings.

-- Absorbing the cost of prenatal care in CPH clinics for women whose income levels are less than $20,000 annually.

-- Requesting hospital to distribute to all new mothers a letter from the Mayor encouraging them to obtain car seats and smoke detectors before leaving the hospital.

-- Expanding the current bus token program in CPH clinics. Patients of the maternity clinics and children accompanying them will be issued METRO fare cards or bus tokens, following a visit.

-- Reducing the waiting times for prenatal and pediatric care by scheduling appointments at specific time slots as opposed tothe current block appointment system.

-- Encouraging mothers to keep clinic appointments by providing assistance for those who bring their children with them to the clinic.

-- Implementing a case management system for high-risk pregnant women and infants so resources may be made available to prevent infant mortality.

MAY 03 1989

NATIONAL COUNCIL OF
JUVENILE AND FAMILY COURT JUDGES

April 26, 1989

Congressman George Miller, Chairman
Select Committee on Children,
 Youth, and Families
385 House Office Building Annex 2
Washington, D. C. 20515

Attn: Ann Rosewater, Staff Director

Dear Chairman Miller:

The National Council applauds you and your Committee's highlighting the epidemic problem of drug-impaired infants. The number of such reported cases in Los Angeles increased from 1 in 1980 to 1500 in 1988. The vast majority of these infants, many abandoned by their addicted mothers at or shortly following their birth, come under the protective jurisdiction of the family or juvenile courts; .hence the concern of our judges nationwide, especially in the largest metropolitan jurisdictions.

Not only are the public health/mental health and drug abuse treatment systems being overwhelmed by the numbers of these cases, but so too are the already swamped child protective services and the foster care systems into which many of these infants must be placed by the court.

This January, following an interdisciplinary two day policy seminar convened by the American Medical Association in which the National Council participated, AMA's Department of Adolescent Health issued a White Paper noting that youth coming under the jurisdiction of our courts represent a "vastly underserved population with greater than average health care needs." Now the National Council, in collaboration with the AMA is embarking on a five-year initiative focusing on the needs of pregnant and postpartum drug impaired adolescents and their infants.

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While we will be unable to attend your Committee's April 27 Hearing, we will follow your work on these issues with great interest. I enclose an outline and appendix materials of a presentation by Robert W. ten Bensel, M.D., MPH to 900 judges and juvenile justice professionals at the Council sponsored 16th National Conference on Juvenile Justice in March. It might be appropriate for inclusion in the Committee's Hearing Report.

Kindest Personal Regards,

Sincerely yours,

Arne Schoeller

Arne Schoeller
Associate Director
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Enc.

UNIVERSITY OF MINNESOTA
SCHOOL OF PUBLIC HEALTH
DIVISION OF HUMAN DEVELOPMENT AND NUTRITION
MATERNAL AND CHILD HEALTH MAJOR

Robert W. ten Bensel, MD, MPH

OBJECTIVES

1. To be able to discuss current medical knowledge on cocaine.
2. To be able to discuss the interrelationship between "crack", "IV" drug use, and AIDS.
3. To be able to discuss the public policy of treatment vs. criminalization as a means of intervention with pregnancy women.

I. THE ISSUES

A. Crack - highly addictive and illegal.

B. Physiology of cocaine
  1. 500 pounds of coco leaves make one pound of cocaine
  2. In its refined form, it is known as crack
  3. Most often additives are used which can cause complications in addiction in addition to the cocaine.
  4. Use is by injection in medicine. Illegal cocaine and its derivatives are either injected intravenously, inhaled through the nose ("snorted"), or smoked.

C. Mechanism of alcohol/cocaine similar
  1. Dopamine depleted
  2. Permanent effects
  3. Behavior - Acute (Pleasure, Power, and Sexual)
  4. Chronic - loss of memory, less pleaure, less sensitive to world

D. Maternal behavioral findings (Cocaine Abuse)
  1. Organic brain syndrome
  2. Bizarre behavior
  3. Paranoid/aggressive behavior
  4. Decreased tolerance to pain

E. Directly affects the health of mother and baby - risk factors.

F. Crack travels with sex (STD & AIDS) and often dangerous - environment.

G. Ethical issues of screening.

H. Law management in mother and child.

I. Is prevention possible?

II. DIAGNOSING COCAINE ADDITION/USE

A. Cocaine - non-medical drug which alters behavior
   1. Similar to alcohol, amphetamines, hypnotics, hallucinogens, PCP, etc.
   2. Major mental effects - intoxication, withdrawal, delirium & delusions.
   3. Narrow "time window" to identify (48 hours)
   4. Denial and withholding information common.

B. DSM Diagnostic Criteria for Cocaine Intoxication (1987)
   1. Recent use of cocaine
   2. Maladaptive behavioral change "impaired judgement" etc.
   3. Physical signs within one hour- rapid pulse, hypertension, chills, nausea or vomiting, dilation of pupils (Note: without laboratory analysis - "provisional")

C. Other cocaine syndromes (DSM-III-R (1987) APA)
   1. Cocaine withdrawal - depression, irritability, anxiety (suicide)
   2. Cocaine delirium - within 24 hours, hallucinations, violent or aggressive behavior
   3. Cocaine delusional disorder - persecutory delusions

D. Addiction definition (Cocaine Pain 1988)
   1. Old - increased tolerance by increasing dose.
   2. New - continued use in face of harmful effects.

E. Drug use in women - ages 18 to 25 (National Survey of Drug Use 1982)
   1. Alcohol: 13,580,000
   2. Cocaine: 2,110,000
   3. Tranquilizers: 1,950,000
   4. Heroin: 90,000

F. Licit vs. illicit drugs (American Heritage Dictionary 1976)
   1. Licit Drugs
      a. From Latin, licitus, "to be permitted", "to be lawful", "leisure"
      b. Within the law, permitted

   2. Illicit Drugs
      a. From Latin, illicitus, "not allowed"
      b. Not sanctioned by custom or law
      c. Illegal, unlawful

G. Cocaine use continues to escalate (Newsweek, 9/23/87)
   1. 20-30 million Americans have tried cocaine
   2. 5 million are regular users
   3. 5000 try cocaine daily for the first time
   4. In 1986 cocaine surpassed alcohol for emergency room visits
   5. Cocaine - 3rd leading cause of drug related deaths
   6. Cocaine is a 50 billion dollar a year drug habit.

III. ASSESSING THE DEGREE OF HARM

A. Degree of harm to cocaine babies
   1. Smaller, pre-term infants, low birth weight
   2. Jitteriness - poor suck
   3. EEG abnormal early (first week)
   4. Babies "poor cuddlers"
      "In a mother who is struggling to deal with her drug craving and related problems, putting a baby in her care - a cuddly, loving baby - is foolhardy. Having one that does not give this type of feedback is even more risky."
      (Jeff Cersonsky, Pediatrics, 1988, 82:136)
   5. Increased risk of sudden infant death syndrome - not proven
   6. Fetal malformations - not proven
   7. "Neonatal Abstinence Syndrome" (withdrawal)

B. Consensus of medical data
   1. Cocaine users older (27 vs. 19 years)
   2. Use more tobacco & alcohol (41% vs. 27%)
   3. More pre-term baby (24% vs. 3%)
   4. Smaller babies (23% vs. 4.3%)
   5. Abrupio placenta (5.7% vs. 1.4%)
   6. No prenatal care (33% vs. 8%)
   7. SIDS higher (15% - not proven)

C. Cocaine effects on brain waves
   (Doberczak, T. et al. J. Pediatrics 1988, 113:354-8)
   1. 39 infants exposed to intrauterine cocaine
   2. 34 irritability; 2 required sedation
   3. EEG - abnormal in 17 of 38 in 1st week of life
   4. 9 of 17 remained abnormal in 2nd week of life
   5. The nine abnormal were normal 3 to 12 months later
   6. Cocaine felt to be transient in brain effects

D. New Data 1989
   1. Temporal patterns of cocaine use in pregnancy
      (Chasnoff, I. et al. JAMA 261: 1741-44, 1989)
      a. Three groups
         i. 1st trimester use - (23)
         ii. Entire pregnancy - (52)
         iii. Control - no use - (40)
      b. Only entire pregnancy - preterm, small for gestational age (head size small)

   2. Effects of maternal marijuana and cocaine use on fetal growth
      (Zuckerman B. et al. NEJM 320:762-8, 1989)
      a. From Boston City Hospital (High risk population)
      b. Controls (no drugs) vs. marijuana users
         i. 79 grams decrease in birth weight ($P = 0.04$)
         ii. 0.5 cm. decrease in length ($P = 0.02$)
      c. Controls vs. cocaine users
         i. 93 gram decrease in weight ($P = 0.07$)
         ii. 0.7 cm. decrease in length ($P = 0.01$)
         iii. 0.43 cm. decrease in head size ($P = 0.01$)

3. "We conclude that the use of marijuana or cocaine during pregnancy is associated with impaired fetal growth." (Zuckerman, et al. 1989)

4. Study Problems
   a. 1932 women eligible
      i. 7% refused (144)
      ii. 6% left clinic (124)
      iii. Usually older, 3rd trimester and smokers

   b. Sample young, low-income, Black and Hispanic
   c. Smoking, STD's, alcohol and heroin correlated

IV. ASSESSING THE RISK FACTORS

A. "It is vital that possible risk factors be evaluated...failure to assess risk appropriately and provide social & community supports may place a further generation of children at risk." (Regan, DD. et al. Infants of Drug Addicts: At Risk for Child Abuse, Neglect, and Placement in Foster Care. Neurotoxicology & Teratology 9:315-317, 1987)

B. Problems with cocaine data 1989
   1. Small numbers of infants studied
   2. Children followed only one year
   3. Lack of control groups
   4. Assessing other maternal factors - alcohol, stress, diet, poverty,etc.
   5. Long term effects unknown

C. "There are no medical problems specific to cocaine." (Dr. Virginia Lupo, Hennepin County, Minneapolis, MN, 3/9/89)

D. Cocaine screening
   1. Not routine
   2. Not random
   3. Medical indicators only (for medical treatment)
   4. Community survey underway (public vs. private patients)
   5. Improving professional education

E. Screening tests are not diagnostic tests, diagnostic tests are "gold standard" tests.

F. The "gold standard" for cocaine is gas chromatography: (99.9%) accurate - urine or blood

G. Iceberg effect masking real proportion of problem
   1. Sample selection basis - High risk deliveries in inner cities - mother and/or infant
   2. Confounding variables - Other substances/environment

H. Interpretation of toxicologic screens (Cocaine presence - illicit, unprescribed use)
1. Cocaine metabolites appear in urine in one hour of exposure
2. Persists for three days (up to five days in neonates)
3. Presence in serum previous eight hours
4. Passive inhalation - not documented

I. General drug screen - urine
1. Alcohol
2. Cocaine
3. Amphetamines
4. Opiates
5. Barbiturates
6. PCP (Phencyclidine)
7. Benzodiazepines
8. THC Metabolite (Marijuana)

J. Cocaine and metabolites screening
(Medtox Laboratories, January 1989)
1. 10 milliliters urine at room temperature
2. Enzyme immunoassay ($18.00) 0.3 ug/ml.
3. Multiple drugs - urine (23.50)
4. Gas chromatography ($40.00) 10 ng/ml.

K. Cocaine in blood
1. 3 ml serum or plasma - 50-200 ng/ml
(infant 10 cc of blood)
2. Gas chromatography
3. Cost - $40.00

L. Perinatal cocaine
1. Few regular screening programs in place
2. Consecutive random screening 10% - 15% are positive at some time during their pregnancy.

M. Cocaine infants in LA (167,000 births/year)
1. 1981 - 1
2. 1982 - 1
3. 1983 - 2
4. 1984 - 10
5. 1986 - 500
6. 1987 - 600
7. 1988 - 1500

N. "Eleven percent (11%) of women in 36 hospitals studied had used illegal drugs, most often cocaine." (375,000 newborns predicted annually) National Association for Perinatal Addiction Research, New York Times 1/89

O. Cocaine use is a high risk factor
1. For other licit and illicit drug misuse
2. For abuse and neglect
3. For intrafamily violence
4. For promiscuous sex
5. For STD's including AIDS

P. Crack and fatal child abuse
(Shirley Press, JAMA, 260:3132, 1988)
  1. 3 battering deaths - 1 mo., 2 yr., 3 yr. old
  2. Children shot to death in crack houses
  3. Sexual and physical abuse in crack houses
  4. (No firm studies on increased deaths)

Q. Cocaine exposure among children
(Shannon, M. et al. Pediatrics March 1989)
  1. 1,680 urine and serum toxicologic screens over 19 months - Boston
  2. 52 (4.6%) positive for cocaine
  3. 4 neonates and 3 infants (1 to 7 months)
  4. 45 were adolescents (mean age 19 years). 19 were suicide attempters or depression and 11 had chronic diseases.
  5. Cocaine abuse among chronically ill adolescents has not been previously documented.
     a. 3 of 11 admitted cocaine abuse
     b. 7 of 11 abuse other drugs

R. Cocaine and adolescents
  1. National Institute Drug Abuse High School Senior Survey (1987) - 15-20% users (up three times from 1987)
  2. Minnesota 1986 - 16.0% males and 16.8% females.

V. PROBLEMS WITH COCAINE TREATMENT

A. For mothers
  1. Lack of treatment facilities for cocaine users
  2. Mother and infant usually separated "boarder babies"
  3. These are the same mothers who were highest risk in the past

B. Cocaine addicts voluntary seeking treatment
(Narcotics Control Digest, March 3, 1989)
  1. In 1985 20% were women
  2. In 1987 50% were women
  3. Of women who were both pregnant & addicted - 20% could not break their habit to deliver a healthy infant

C. The medical logic for mothers with cocaine use
  1. Screening of mothers on medical indication
  2. Screening of babies if mother's positive (repeat)
  3. CPS referral - parent and home assessment - patterns of behavior

D. Issues to address with cocaine misuse
  1. Cocaine may be harmful
  2. Poor illicit drug use and licit drug abuse - tobacco and alcohol
  3. Poor nutritional status
  4. Poor social environment - home visit and assess parenting skills and safety needs

E. Social policy
  1. Prenatal substance abuse - licit or illicit constitutes child abuse.
  2. Clear and objective of the limitations of scientific findings as well as the extent of findings.

F. Public health policy
   1. Prevention - education, legislation and enforcement (prohibit use of all drugs during pregnancy)
   2. Screening - early identification of drug use
   3. Treatment - "commitment for treatment"

G. Focus on larger issues
   1. Overriding issue is society's support of families and pregnant women.
   2. Creating a "duty to have a healthy child"
   3. Creating an ethical responsibility to care for self and others (compassion)
   4. Looking at ourselves - the licit and illicit use of drugs (chemical health)

VI. NEW ISSUES

A. "The sex drug"
   Crack users increasing sexual activity -- for drugs as well as for sex (prostitution)

B. The two major public health epidemics are now interconnected
   HIV infection and IV drugs
   (48 Hours, 10/13/88)

C. AIDS and Syphilis ("Ghetto diseases")
   1. More in minorities
   2. Money shifted to AIDS
   3. More screening of patients in inner city hospitals, drug user and prostitutes (Wall Street Journal 12/19/88)

D. Syphilis and crack
   1. Syphilis - rising
      inner city drug users, prostitutes and contacts; decline in gay men
   2. Women trade sex for crack - more contacts than prostitutes
   3. The "crack house" is the "gay bath house" of the 1970's.
      (Wall Street Journal, 12/19/88.)

E. Homemade drugs
   1. In home labs, the U.S. has the capability of making all of the illicit drugs it needs even if all foreign sources are stopped.
   2. China White - 700 times more powerful than heroin
   3. PCP - "angel dust"
   4. LSD - exported to other countries
   5. Metamphenamines

VII. LEGAL ISSUES IN INTERVENTION

A. When courts take charge of the unborn
   1. 29 year old woman - forging checks was pregnant and screened for cocaine
   2. Mother sentenced to jail until baby was delivered (12 weeks)

B. Current trends in law enforcement
  1. Screening for drugs in newborn's urine.
  2. "Women who are pregnant and committing crimes are being punished more harshly" (Temar Lewin, New York Times, 1/89)
  3. The newborn's urine showing cocaine is used as evidence of mother's illegal drug use (single screening being contested).

  4. "In most states, it is still an open legal question whether a pregnant women's drug abuse constitutes child neglect (fetal abuse) or is a 'legal wrong'." (New York Times, 1/89)

C. Obligation to protect fetus
  1. PRO - "Prosecutors, judges & state child protection" (& many physicians)
  2. CON -
    a. Unconstitutional
    b. Laws more harshly applied in cocaine and other illicit drugs
    c. More drug treatment programs for pregnant women needed.

D. Laws - fetal and perinatal
  1. Right to inherit property (March v. Kirby, 1937)
  2. Right to recovery - traumatic physical injury (Bonbrest V. Kotz, 1946)
  3. Doctrine of intrafamilial immunity - limits actions for damage could not be brought against immediate family.
  4. Right to pregnant women's body integrity
  5. Is the fetus a child (unborn child)?

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APPENDIX A

Summary of Studies on Incidence and Prevalence of Cocaine use among Pregnant Women

REFERENCE	METHODS	FINDINGS
Frank, D.A. et. al, 1988	Assessment by interviews & urine Analysis, Prenatally & post-partum, of 679 urban women participants. No significant difference with the nonparticipants was detected.	17% used cocaine at least once. 8% were positive by urine assays. 24% denied use at interview but were positive in urine. 11% 1st. Trimester. 7% 2nd. Trimester. 9% 3rd. Trimester. 6% Pre-partum. Among users, (61% positive by urine assay) 18% used it during all prenancy, 48% only during 1st or 2nd Trimester, 33% within last 7 days.
Cherukuri, R. et. al., 1988	Retrospective matched cohort study of 55 cocaine-using women and non-drug-using women. Matched for age, parity, SE status, alcohol use and presence or absence of prenatal care.	4% of all deliveries (114) used cocaine at least once.
Little, B.B. et. al., 1988	Retrospective study on 102 hospital records of a large public hospital which serves a predominantly indigent population.	Estimated prevalence = 9.8% (SE level = 1. 3.9 - 15.7% range 60% multi-drugs users.
Chasnoff, I.J. et. al., 1984	Screening of all women presenting to the Women's Hospital in Chicago for prenatal care during a 6 month trial period in 1982.	3% of women evidenced sedative-hypnotics in urine at time of admission to clinic.

Frank, D.A., et al: Cocaine Use During Pregnancy: Prevalence and Correlates. Pediatrics 82(6): 888-895, 1988.
Cheruki, R., et al: A Cohort Study of Alkaloidal Cocaine ("Crack") in Pregnancy. Obstetrics & Gynecology 72(2): 142-151, 1988.
Little, B.B. et al: Cocaine Use in Pregnant Women in a Large Public Hospital. American Journal of Perinatology 5(3): 206-207, 1988.
Chasnoff, I.J. et al: Maternal Non-Narcotice Substance Abuse During Pregnancy: Effects on Infant Development. Neuro-behavioral Toxicology Teratology 6: 277-290, 1984.

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Prepared by Walter Suarez, MD 1/89

APPENDIX B

Major Characteristics of the Population At Risk of Using Cocaine During Pregnancy

Characteristic	Range	Significance
Maternal Age (yrs)	27.0 ± 4.2	(*)
Weight Gain (lbs)	27.1 ± 12.0	(*)
Tobacco Use > 19/day	29 (41.4%)	(*)
Alcohol > 5 drks/wk	8 (11.4%)	(*)
Ethnic Background		
... White		(**)
... North American Black		(**)
... Other Black		(*)
... Hispanic		(*)
... Other		(**)
Marital Status		
... Single		(**)
... Married		(*)
Level of Education		(*)
Employed		(*)
Gravidity	3.8 ± 2.0	(**)
Parity	1.1 ± 1.3	(*)
Prenatal Visits	7.9 ± 4.1	(**)
STDs		(**)
Abortions		(**)
Nutritional Status		(**)

(*) No Significance (**) $p < 0.05$

Source: MacGregor, S.N., et al: Cocaine Use During Pregnancy: Adverse Perinatal Outcomes. American Journal of Obstetrics and Gynecology 157: 686-690, 1987.

Frank, D.A., et al: Cocaine Use During Pregnancy: Prevalence and Correlates. Pediatrics 82 (6): 883-895, 1988.

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APPENDIX C

Perinatal Effects of the use of Cocaine during Pregnancy

Parameter	Range	Significance
Gestational Age	37.1 ± 3/6	(***)
Preterm Labor (a)	15 (78.6%)	(**)
Preterm Delivery (a)	17 (24.3%)	(***)
Birth Weight (gm)	2853 ± 698	(***)
Low Birth Weight (b)	16 (22.9%)	(**)
Small for Gest. Age	13 (18.6%)	(**)
Route of Delivery		
... Vaginal	55 (78.6%)	(*)
... Primary Cesarean	8 (11.4%)	(*)
... Repeated Cesarean	7 (10.0%)	(*)
Abruptio Placentae	5 (7.1%)	(*)
Congenital Anomalies	4 (5.7%)	(*)
PROM (c)	(32.0%)	(**)
Meconium-Stained Fluid	(21.0%)	(*)
Head Circum. (%tile)	25	(**)

(*): No Significance; (**): $p < 0.05$; (***): $p < 0.005$
(a): < 37 weeks; (b): < 10 %tile; (c): Premature
Rupture of Membranes

Sources:

Frank, D.A., et al: Cocaine Use During Pregnancy: Prevalence and Correlates. Pediatrics 82(6): 888-895, 1988.
Cheruki, R., et al: A Cohort Study of Alkaloidal Cocaine ("Crack") in Pregnancy. Obstetrics & Gynecology 72(2): 142-151, 1988.
MacGregor, S.N., et al: Cocaine Use During Pregnancy: Adverse Perinatal Outcomes. American Journal of Obstetrics and Gynecology 157: 686-690, 1987.
Chouteau, M., et al: Effects of Cocaine Abuse in Birth Weight and Gestational Age. Obstetrics & Gynecology 72(3): 351-354, 1988.
Doberczak, T.M., et al: Impact of Maternal Drug Dependency on Birth Weight and Head Circumference of Off-springs. American Journal of Disease in Children 141: 1163-1167, 1987.

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Prepared by Walter Suarez, MD 3/89

APPENDIX D

Immediate Outcomes on the Newborn Exposed to Cocaine

Reference	Method	Findings
Bingol, N. et al, 1987.	Triple cohort study involving cocaine-using mothers, multi-drug abusers and drug-free mothers.	Congenital malformation rate was significantly higher for group 1 vs group 3 ($p < 0.01$). Stillbirth rate was significantly higher in group 1 ($p < 0.01$).
Bauchner, H. et al, 1988.	Cohort study of 996 women from which 175 used cocaine during pregnancy.	A risk of 5.6/1000 of SIDS(a) within users compared to 4.9/1000 of the non-user group. A relative risk of 1.17 with a 95% CI of 0.13 - 10.43 within users suggested no increase risk to SIDS.
Shih, L. et al, 1988.	Case-control study on 36 newborns. 18 neonates born to cocaine-using mothers. Tests for peripheral and brainstem auditory dysfunction were performed.	ABRs from neonates exposed to prenatal cocaine abuse showed prolonged latencies indicating neurologic impairment or dysfunction requiring further audiologic and neurologic follow up.
Telsey, A.M. et al, 1988.	A case study analysis of gastro-intestinal complication on newborns exposed to cocaine.	A case of necrotizing enterocolitis at birth in a term neonate is presented. Culture of bowel secretion was + for 2 types of Clostridia, E.Coli and Group B Streptoccoccus. It is suggested that bowel ischemia was due the vasoconstrictive properties of cocaine. A 2nd complication of exposure to cocaine is suggested: Ischemic infarction of the bowel.

APPENDIX D

- continuation -

Reference	Method	Findings
Doberczak, T.M. et al, 1988.	39 infants with intrauterine exposure to cocaine were examined for neurologic and EEG abnormalities.	34 of 39 displayed CNS irritability, only 2 requiring sedation. EEG was abnormal in 17 of 38 during the first week of life. The main abnormality was a pattern of irritability. Follow-up showed a reversal to normalized patterns in 90%.
Chasnoff, I.J. et al, 1985.	23 cocaine-using pregnant women were enrolled in 2 cohorts: cocaine users alone and multidrug users. They were compared to women under methadone during pregnancy and a group of drug-free women.	The Brazelton Neonatal Behavioral Assessment Scale revealed that infants exposed to cocaine had significant depression of interactive behavior and a poor organizational response to environment stimulii.
Ostrea, E.M. et al, 1987.	A case control study of 12 exposed infants and 19 controls was done to evaluate the patterns of heart rate.	A significant higher heart-rate baseline, beat-to-beat variability and long-term variability. Serum creatin phosphockinase was elevated and 39% of it was the MM fraction.
Isenberg, S.J. et al, 1987.	A case control study of 13 cocaine-intoxicated neonates and 36 controls was done to evaluate the existence of ocular abnormalities.	Iris blood vessel abnormalities were found ranging from no visible vessels (grade 0) to dilated and tortuous vessels (grade 4).
Teske, M.P. et al, 1987.	A case study report of effects of cocaine exposure in the ocular system.	A case of Retinophaty of prematurity-like fundus and persistent hyperplastic primary vitreous was reported to be associated to cocaine exposure.

APPENDIX D

- continuation -

Reference	Method	Findings
Chasnoff, I.J. et al, 1986.	A case study report of the effect of cocaine exposure over the cerebrovascular system.	The case of a neonate exposed to a high dose of cocaine during the last 3 days of pregnancy was presented. Complications during the initial 24 hours of life included episodes of apnea and cyanosis, followed by multiple focal seizures The diagnostic evaluation was conclusive of acute infarction of the left middle cerebral artery.
Davidson, S.L. et al, 1986.	A case control study of 27 cocaine-exposed neonates and 43 controls was done to assess pattern functions.	The study reported a longer total sleep time with greater durations of apnea and higher total duration of apneas >=6 sec. More periodic breathing, a higher mean respiratory rate and a lower mean heart rate.
Chasnoff, I.J. et al, 1987.	A case study report of the the presence of cocaine in breast milk.	A case report of a 2 week old infant girl who was exposed to cocaine via her mother's breast milk serve to present the patterns of excretion of the drug in breast milk compared with infant excretion patterns. Significant levels persisted up to 36 hours after use.

APPENDIX D

- continuation -

Sources:

Bingol, N. et al: Teratogenicity of Cocaine in Humans. The Journal of Pediatrics 110: 93-96, 1987.

Bauchner, A. et al: Risk of Sudden Infant DDeath Syndrome among Infants with In-Utero Exposure to Cocaine. The Journal of Pediatrics 113:831-834, 1988.

Shih, L. et al: Effects of Maternal Cocaine Abuse on the Neonatal Auditory System. International Journal of Pediatric Otorhinolaryngology 15:245-251,1988.

Telsey, A.M. et al: Cocaine Exposure in a Term Neonate: Necrotizing Enterocolitis as a Complication. Clinical Pediatrics 27(11): 547-549, 1988.

Doberczak, T.M. et al: Neonatal Neurologic and EEG effect of Intra-Uterine Cocaine Exposure. The Journal of Pediatrics 113: 354-358, 1988.

Chasnoff, I.J. et al: Cocaine Use in Pregnancy. New England Journal of Medicine, 313: 666-669, 1985.

Ostrea, E. M. et al: Abnormal Heart Rate Tracing and Serum Creatin Phosphokinase in Addicted Neonates. Neurotoxicology and Teratology 9: 305-309, 1987.

Isenberg, S. I. et al: Ocular Signs of Cocaine Intoxication in Neonates. American Journal of Ophthalmology 103: 211-214, 1987.

Teske, M.P. et al: Rethinopathy of Prematurity-Like Fundus and Persistent Hyperplastic Primary Vitreous Associated with Maternal Cocaine Use. American Journal of Ophthalmology 105(6): 719-720, 1987.

Chasnoff, I.J. et al: Perinatal Cerebral Infarction and Maternal Cocaine Use. The Journal of Pediatrics 108(3): 456-459, 1986.

Davidson, S.L. et al: Abnormal Sleeping Ventilatory Patterns in Infants of Substance Abuse Mothers. American Journal of Disease in Children 140: 1015-1020, 1986.

Chasnoff, I.J. t al: Cocaine Intoxication in a Breast-Fed Infant. Pediatrics 80: 836-838, 1987.

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Prepared by Walter Suarez, MD 3/89

APPENDIX E

I. Urine drug screens will be requested by the physicians in the following circumstances:

- A. Documented or history of maternal substance abuse
- B. No prenatal care
- C. Abruption
- D. Preterm Labor
  - 1. With vaginal bleeding
  - 2. With unexplained fetal distress

II. Urine drug screens may be requested by the physicians in the following circumstances, obtain first voided urine and save in refrigerator:

- A. Sexually transmitted diseases
- B. Hepatitis B
- C. HIV antibody positive
- D. Small for gestational age - with small head size
- E. CNS abnormalities
  - 1. With seizures
  - 2. With tremulousness
- F. Irritability
  - 1. Associated tachypnea
  - 2. Associated tachycardia

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APPENDIX F

I. Urine screens for cocaine and other drugs will be sent on all babies whos mothers have been screened on admission to labor and delivery, whose mothers have tested positive for cocaine on urine screeening during the pregnancy, or whose mothers have admitted to the use of cocaine during pregnancy.

II. Urine screens for cocaine and other drugs will be sent on all newborns whose mothers have had no or minimal prenatal care.

III. Newborns who test positive for cocaine, or whose mothers test positive on admission to labor and delivery should be observed in the newborn nursery for a minimum of 72 hours after delivery for signs of drug withdrawal.

IV. Breast feeding is contra-indicated if the maternal urine is positive for cocaine, and should be strongly discouraged for mothers who are likely to resume drug abuse after discharge from the hospital.

Hennepin County Medical Center 3/2/89

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